

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23501

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Elizabeth Schloss Hirsh					2. Date of Death Month Day Year AUG 1 1997		3. Time of Death 11:10 PM		
	4a. Facility Name (If not institution, give street and number) 830 W. 40th St., #650					4b. City, Town, or Location of Death Baltimore		4c. County of Death N/A		
Funeral Director	5. Social Security Number 214-44-7660		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 83 Yrs.		8. Date of Birth (Month, Day, Year) MAR 8, 1914		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent					10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No					10e. Street and Number 830 W. 40th St., #650		10f. Zip Code 21211		10g. Citizen of What Country? USA	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+					16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker			16b. Kind of Business/Industry Own Home		
17. Father's Name (First, Middle, Last) Harry O. Schloss					18. Mother's Name (First, Middle, Maiden Surname) Fannye Kerngood					
19a. Informant's Name/Relationship (Type, Print) Elizabeth H. Warshawsky/Daughter					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2839 S. Park Blvd. Sharker Heights, OH 44120					
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc. 8/4/97			20c. Location - City or Town, State Baltimore, MD				
21. Signature of Funeral Service Licensee Edward A. Gregorchik					22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) Breast Cancer Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									Approximate Interval Between Onset and Death 6mo	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier J. Glehart					29c. License number D33400			29d. Date signed (Month, Day, Year) 08/04/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Iredell W. Glehart MD 500 W University Pkwy Baltimore MD 21201										
31. Date filed (Month, Day, Year) AUG 05 1997			32. Registrar's Signature John Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





LEONIMUS  
HART

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23502

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LEONIMUS HART</b>				2. Date of Death Month Day Year <b>AUGUST 1 1997</b>		3. Time of Death <b>10:43 P.M.</b>	
	4e. Facility Name (If not Institution, give street and number) <b>1107 N. RUTLAND AVE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-38-7570</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>55</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>9/26/41</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1107 RUTLAND AVENUE</b>				10f. Zip Code <b>21205</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>N/A</b>		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>STORE KEEPER</b>		16b. Kind of Business/Industry <b>DEPT. PUBLIC WORKS</b>			
17. Father's Name (First, Middle, Last) <b>HENRY HART, SR</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ALLIE HAMILTON</b>				
19a. Informant's Name/Relationship (Type, Print) <b>KEVIN HART / SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1107 RUTLAND AVE., BALTO. MD 21205</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING PARK CEMETERY</b>		Date <b>8/6/97</b>		20c. Location - City or Town, State <b>RANDALLSTOWN</b>		
21. Signature of Funeral Service Licensee <b>Vaughn C. Greene</b>				22. Name and Address of Facility <b>VAUGHN C. GREENE FUNERAL SERVICE 5151 BALTO. NAT'L PIKE, BALTO. MD 21229</b>				
23a. Pertinent, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>Atherosclerotic cardiovascular disease</b> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Human immunodeficiency virus sero positivity.</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>AM DIXON</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 2, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>AM DIXON 111 Penn Street, Baltimore, Maryland 21201</b>								
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>		32. Registrar's Signature <b>Juba Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene

97 23503

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Esther L. Harris</u>				2. Date of Death Month <u>July</u> Day <u>31</u> Year <u>1997</u>		3. Time of Death <u>21:32</u>	
	4a. Facility Name (If not institution, give street and number) <u>Bayview medical Center</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>NA</u>	
Funeral Director	5. Social Security Number <u>218-18-8338</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <u>94</u> Yrs.		8. Date of Birth (Month, Day, Year) <u>July 12 03</u>	
	10a. State <u>Maryland</u>		10b. County <u>NA</u>		10c. City, Town or Location <u>Baltimore</u>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (14 or 5+) <u>NA</u>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Assembly Line</u>		16b. Kind of Business/Industry <u>Military Hardware</u>				
17. Father's Name (First, Middle, Last) <u>Charles D. Harris</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Frances Becraft</u>				
19a. Informant's Name/Relationship (Type, Print) <u>Charles D. Harris Jr. Grandson</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>809 Barbara Court Glen Burnie, Md. 21060</u>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Prospect</u>		20c. Location - City or Town, State <u>August</u>		20d. Location - City or Town, State <u>4 Mt. Airey, Md.</u>		
21. Signature of Funeral Service Licensee <u>[Signature]</u>				22. Name and Address of Facility <u>W. Dabrowski / Chojnacki F.H.P.A.</u> <u>1005 Dundalk Ave. Balto., Md. 21224</u>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <u>Cardiogenic shock</u> Due to (or as a consequence of): b. <u>Sepsis</u> Due to (or as a consequence of): c. <u>aspiration pneumonia</u> Due to (or as a consequence of): d. <u>Stroke</u>				Approximate Interval Between Onset and Death <u>24 hrs</u> <u>24 hrs</u> <u>2 days</u> <u>5 days</u>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		
		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <u>[Signature]</u>		29c. License number <u>96706</u>		29d. Date signed (Month, Day, Year) <u>7/31/97</u>		
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <u>ERIC E. Howell Bayview medical Center</u>								
31. Date filed (Month, Day, Year) <u>AUG 05 1997</u>		32. Registrar's Signature <u>[Signature]</u>						

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23504

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARGARET HAND</b>				2. Date of Death Month Day Year <b>AUGUST 1, 1997</b>		3. Time of Death <b>4:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>217 09 7130</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JAN. 25, 1905</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MARYLAND</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>Towson</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>8427 LOCH RAVEN BLVD.</b>				10f. Zip Code <b>21286</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 YRS.</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HAT MAKER</b>		16b. Kind of Business/Industry <b>LEVY COMPANY</b>				
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>ANTHONY LEMMER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FRANCES Remy</b>				
	19a. Informant's Name/Relationship (Type, Print) <b>GEORGE F. HAND, SR.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3303 WOODSIDE AVE. PARKVILLE MARYLAND 21234</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		Date <b>AUG. 4, 1997</b>		20c. Location - City or Town, State <b>PARKVILLE MARYLAND</b>		
	21. Signature of Funeral Service Licensee <i>[Signature]</i>		22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARTFORD PARKVILLE MARYLAND 21234</b>						
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Emphysema</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death	
	b. Due to (or as a consequence of):								
	c. Due to (or as a consequence of):								
	d. Due to (or as a consequence of):								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							
		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Francis L. Wiegman, M.D.</i>				29c. License number <b>D25569</b>		29d. Date signed (Month, Day, Year) <b>8/1/97</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Francis L. Wiegman, Jr. M.D. / 8406 Hartford Rd. / Baltimore, Md. 21234</b>									
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>		32. Registrar's Signature <i>Gina Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

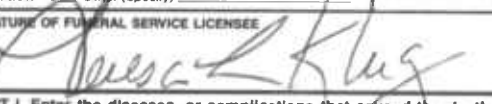


To Be Completed by Funeral Director



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ellen B. Hickey</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 1st 1997</b>				3. TIME OF DEATH <b>8:25P</b>					
4. SOCIAL SECURITY NUMBER <b>213-05-1058</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 26 1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Catonsville Commons</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Catonsville</b>						9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2830 Pennsylvania Avenue</b>						10f. ZIP CODE <b>21227</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6</b> <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>					
17. FATHER'S NAME (First, Middle, Last) <b>George Metcalf</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henrietta (Unknown)</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Donna Saia / daughter</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2830 Pennsylvania Ave Balto, MD 21227</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill Cemetery 8/4</b>				20c. LOCATION — City or Town, State <b>Baltimore, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME, INC.</b> <b>4107 Wilkens Ave, Baltimore, MD 21229</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>CHRONIC SUB-DURAL HEMATOMA with Complications</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ATHEROSCLEROTIC, HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATHEROSCLEROTIC, HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												Approximate Interval Between Onset and Death <b>8 weeks</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>JUNE 5, 1997</b>		28b. TIME OF INJURY <b>AM</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>FELL &amp; STRIPS</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>AT HOME</b>						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>5638 BRAXFIELD ROAD BALTIMORE MD 21227</b>							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>D 30469</b>			29d. DATE SIGNED (Month, Day, Year) <b>August 2, 1997</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>N.B. VELLANKI, 9055 CHEVROLET DRIVE, #100, ELIOTT CITY, MD 21042</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 05 1997</b>				32. REGISTRAR'S SIGNATURE 									

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

JA





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23506

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Hutchinson

2. Date of Death

Month  
JULY

Day

30, 1997

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

613 S. Wickham Rd.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-09-5996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
NOV. 22, 1919

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

613 S. Wickham Rd.

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Stanley Milesky

18. Mother's Name (First, Middle, Maiden Surname)

Julia E. Cautwell

19a. Informant's Name/Relationship (Type, Print)

John C. Hutchinson - son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

114 Sunlight Circle, Glen Burnie, Md. 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest VA Cem.

Date

8/1/97

20c. Location - City or Town, State

Owings Mills, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge  
7250 Washington Blvd., Elkridge, Md. 21075

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Coronary Artery Disease

Approximate Interval Between Onset and Death

5 min

Due to (or as a consequence of):

b. Atrial Fibrillation

2 years

Due to (or as a consequence of):

c. ASCVD (Atherosclerotic cardiovascular disease)

10 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D44243

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J.W. Cook MD 516 N. Rollins Road #608 Catonsville MD 21228

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

WILLIAM ALBERT HALEY, JR.

2. Date of Death

Month Day Year  
JULY 30, 1997

3. Time of Death

0942AM

4a. Facility Name (If not institution, give street and number)

CALVERT MEMORIAL HOSPITAL E.R.

4b. City, Town, or Location of Death

PRINCE FREDERICK CALVERT COUNTY

4c. County of Death

5. Social Security Number

219-82-8621

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

37 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Mar 30, 1960

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

KENT

10c. City, Town or Location

CHESTERTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

108 Woodduck Lane

10f. Zip Code

21620

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

grade 10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Wrecker driver

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

William Albert Hailey, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Edna May Marie Jacobs

19a. Informant's Name/Relationship (Type, Print)

Betty J. Hailey, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Woodduck Lane, Chestertown, MD 21620

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Pk. Aug 4 97 Elkridge, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gary L. Kaufman Funeral Home at Meadowridge

Memorial Park, 7250 Washington Blvd, Elkridge

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☒ Yes 2 ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☒ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

John Radentz

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23508

ITEM# 19a PER F.H. ELM#G750 8-5-97 J.A. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Damon Maurice Jefferson Sr.</b>						2. Date of Death Month Day Year <b>JULY 30, 1997</b>		3. Time of Death <b>23:30 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>2940 ARUNAH AVENUE</b>						4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>217-84-2867</b>		6. Sex <b>1</b> M <b>2</b> F		7. Age (In yrs. last birthday) <b>22</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-11-74</b>		9. Birthplace (State or Foreign Country) <b>MD</b>		
	Usual Residence of Decedent										
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>				10d. Inside City Limits <b>1</b> Yes <b>2</b> No			
10e. Street and Number <b>960 Franklinton Rd</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>					
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>STEEL CO.</b>				
17. Father's Name (First, Middle, Last) <b>VERNON Riddick</b>						18. Mother's Name (First, Middle, Maiden Surname) <b>Davena Jefferson</b>					
19a. Informant's Name/Relationship (Type, Print) <b>DAVENA Jefferson</b>						19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>960 FRANKLINTOWN RD. BALTO, MD 21216</b>					
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION</b>		20c. Location - City or Town, State <b>8/19/97 Lansdowne, MD</b>							
21. Signature of Funeral Service Licensee <b>Wagner C. Hury</b>				22. Name and Address of Facility <b>about P. Wylie F/H PH 638 N. Guilmon ST. Balto. MD 21217</b>							
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Gunshot Wounds</b> Due to (or as a consequence of):  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last										Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown	
										24e. Was an autopsy performed? <b>1</b> Yes <b>2</b> No	
										24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No	
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No				26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) <b>SCENE</b>							
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year) <b>7-30-97</b>		28b. Time of Injury <b>23:25 M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how Injury occurred <b>Subject was shot</b>			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2940 Arunah Baltimore City, Maryland</b>							
29a. Certifier (Check only one) <b>2</b> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Stephen S. Radentz, MD</b>									
29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>JULY 31, 1997</b>									
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>											
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>				32. Registrar's Signature <b>Julia Davidson-Randall</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23509

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BIANCA JANE JAMES

2. Date of Death

Month  
APRILDay  
13Year  
1997

3. Time of Death

11:20 AM

4a. Facility Name (If not institution, give street and number)

HARFORD MEMORIAL HOSPITAL UNION AVE

4b. City, Town, or Location of Death

HARVE DE GRACE

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

NONE

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Month, Day, Year

9. Birthplace (State or Foreign Country)

APRIL 13, 1997

10. Inside City Limits

1 ☒ Yes 2 ☐ No

Usual Residence of Decedent

10a. State

MD

10b. County

HARFORD

10c. City, Town or Location

APG

10e. Street and Number

2931 D BEACH COURT

10f. Zip Code

21005

10g. Citizen of What Country?

US

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

0

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

INFANT

16b. Kind of Business/Industry

INFANT

17. Father's Name (First, Middle, Last)

STANLEY EUGENE JAMES

18. Mother's Name (First, Middle, Maiden Surname)

CYNTHIA COLEY

19a. Informant's Name/Relationship (Type, Print)

MOTHER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2931 D BEACH COURT APG, MD 21005

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street

Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Prevalable Fetus

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Incomplete Cervix

Prevalable delivery (2nd trimester) Spontaneous Abortion

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

James Swenbeck

29c. License number

DH117

29d. Date signed (Month, Day, Year)

6/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Swenbeck MD

607 S Union Ave

Harve de Grace MD

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23510

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Sydney Jackson</u>				2. Date of Death Month <u>July</u> Day <u>30</u> Year <u>1997</u>		3. Time of Death <u>9:15 pm</u>									
	4a. Facility Name (If not institution, give street and number) <u>Sinai Hospital</u>				4b. City, Town, or Location of Death <u>Baltimore</u>		4c. County of Death <u>N/A</u>									
Funeral Director	5. Social Security Number <u>213-26-8983</u>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <u>66</u> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <u>SEP 26, 1930</u>									
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <u>Maryland</u>													
To Be Completed by Funeral Director	10a. State <u>MD</u>	10b. County <u>N/A</u>	10c. City, Town or Location <u>Baltimore</u>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No										
	10e. Street and Number <u>2607 Elsinore Avenue</u>			10f. Zip Code <u>21216</u>		10g. Citizen of What Country? <u>USA</u>										
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>Black</u>									
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <u>1</u> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <u>Administrator</u>		16b. Kind of Business/Industry <u>Social Security</u>											
	17. Father's Name (First, Middle, Last) <u>Sydney Warren Ransom</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Dorothy M. Jackson</u>											
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <u>Yasmin Jackson/daughter</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6812 Townbrook Dr. Apt. C Baltimore, MD 21207</u>											
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Metro Crematory, Inc.</u>		Date <u>8/1/97</u>		20c. Location - City or Town, State <u>Baltimore, MD</u>									
	21. Signature of Funeral Service Licensee <u>Edward A. Gaborchik</u>				22. Name and Address of Facility <u>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</u>											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Hemorrhagic Pancreatitis</u></td> <td>Approximate Interval Between Onset and Death <u>weeks</u></td> </tr> <tr> <td>b. <u>Antiretroviral Medication</u></td> <td><u>years</u></td> </tr> <tr> <td>c. <u>Acquired Immune Deficiency Syndrome</u></td> <td><u>years</u></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Hemorrhagic Pancreatitis</u>	Approximate Interval Between Onset and Death <u>weeks</u>	b. <u>Antiretroviral Medication</u>	<u>years</u>	c. <u>Acquired Immune Deficiency Syndrome</u>	<u>years</u>	d.
Immediate Cause (Final disease or condition resulting in death)	a. <u>Hemorrhagic Pancreatitis</u>	Approximate Interval Between Onset and Death <u>weeks</u>														
	b. <u>Antiretroviral Medication</u>	<u>years</u>														
	c. <u>Acquired Immune Deficiency Syndrome</u>	<u>years</u>														
	d.															
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <u>M</u>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No										
		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)												
		28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																
29b. Signature and title of certifier <u>Dr. David physician</u>				29c. License number <u>AS2402321HP9940</u>		29d. Date signed (Month, Day, Year) <u>July 30, 1997</u>										
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>Helen Powell, MD Sinai Hospital Baltimore, Maryland</u>																
31. Date filed (Month, Day, Year) <u>AUG 05 1997</u>				32. Registrar's Signature <u>Julia Davidson-Randall</u>												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

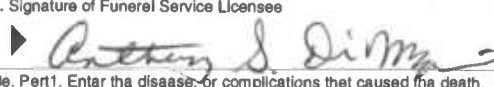

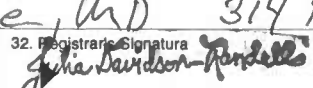
State of Maryland / Department of Health and Mental Hygiene

97 23511

Item 41,10e,19b Per FH 8-12-97 rja

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>OLLIE EDWARD JENKINS</b>				2. Date of Death Month <b>8</b> Day <b>2</b> Year <b>97</b>		3. Time of Death <b>1:15 AM</b>		
	4a. Facility Name (If not institution, give street and number) <b>13907 Sand Dune RD Apt. 7A</b>				4b. City, Town, or Location of Death <b>Ocean City</b>		4c. County of Death <b>Worcester</b>		
Funeral Director	5. Social Security Number <b>217-03-2086</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>8/15/17</b>	9. Birthplace (State or Foreign Country) <b>VA</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Worcester</b>		10c. City, Town or Location <b>Ocean City</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>13907 Sand Dune RD Apt. 7A</b>				10f. Zip Code <b>21842</b>		10g. Citizen of What Country? <b>USA</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1945-46</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Construction Manager</b>				18b. Kind of Business/Industry <b>Land Development</b>		
	17. Father's Name (First, Middle, Last) <b>Robert Jenkins</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lindsey Dodson</b>				
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) <b>Virginia Jenkins /Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13907 Sand Dune RD Apt. 7A Ocean City, MD 21842</b>				
	20e. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Loudon Park Mausoleum</b>		Date <b>8/6/97</b>		20c. Location - City or Town, State <b>Baltimore City, MD</b>		
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Loudon Park Funeral Home 3620 Wilkens Ave., Baltimore, MD 21229</b>				
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>cardio pulmonary arrest</b> Due to (or as a consequence of): b. <b>Metastatic non small cell Carcinoma of lung</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier  MD		29c. License number <b>D31974</b>		29d. Date signed (Month, Day, Year) <b>8/4/97</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Douglas Bruce, MD 314 Franklin Ave, Berlin, Md 20811</b>									
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23512

Item: 5 Per Fh Film G-754 12/18/97RC

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Johnson</b>		2. Date of Death Month <b>August</b> Day <b>03</b> Year <b>1997</b>		3. Time of Death <b>9 PM</b>
	4a. Facility Name (If not institution, give street and number) <b>STELLA MARIS AT MERCY HOSP.</b>		4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>191-20-7897</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JAN. 24, 1927</b>		9. Birthplace (State or Foreign Country) <b>WEST VIRGINIA</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent		10a. State <b>MARYLAND</b>		10b. County <b>N/A</b>
	10c. City, Town or Location <b>BALTIMORE CITY</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number <b>1809 E. LAFAYETTE AVE.</b>		10f. Zip Code <b>21213</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>NEGRO</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11TH</b> Collage (1-4 or 5+) <b>N/A</b>		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CLERK/CASHIER</b>		16b. Kind of Business/Industry <b>DEPARTMENT STORE</b>		
	17. Father's Name (First, Middle, Last) <b>ROBERT LEWIS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>WILLANA HARRIS</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>PEARL SAVAGE - niece</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>218 4TH AVENUE ALIQUIPPA, PA. 15001</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		20c. Location - City or Town, State <b>AUG. 7, 1997 BALTO, MD.</b>
	21. Signature of Funeral Service Licensee <b>Calvin B. Scruggs, Jr.</b>		22. Name and Address of Facility <b>CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 21213</b>		
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Lung metastasis</b></p> <p>b. <b>Breast Cancer</b></p> <p>c. _____</p> <p>d. _____</p> </div> <div> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</p> </div> </div>					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>STELLA MARIS AT MERCY HOSPICE</b>					
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined					
28a. Date of Injury (Month, Day, Year) <b>August 4, 1997</b>					
28b. Time of Injury <b>M</b>					
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
28d. Describe how injury occurred					
28e. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier <b>Dr. Fernando J. Ferrer, MD</b>					
29c. License number <b>040480</b>					
29d. Date signed (Month, Day, Year) <b>August 4, 1997</b>					
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>FERNANDO J. FERRER, MD 5810 BELAIR RD BALTO, MD 21206</b>					
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>					
32. Registrar's Signature <b>Johnson-Pendall</b>					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23513

ITEM#24a PER PHYNS. FLM#G750 8/5/97 J.A.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jean Kennedy

2. Date of Death

Month 7 Day 14 Year 97

3. Time of Death

1456

4a. Facility Name (If not institution, give street and number)

Umms

4b. City, Town, or Location of Death

Bait

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-22-9799

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

68

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 30, 1928

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

unknown

☐ Yes ☒ No

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? ☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Acute Myocardial Infarction  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. Ischemic Bowel  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Wade Graesch, MD

29c. License number

037818

29d. Date signed (Month, Day, Year)

7/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wade Graesch Umms

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Jelia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23514

ITEM# 10d PER F.H. FLM#G750 8/5/97 J.A.

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>FANNIE KESSLER</b>		2. Date of Death Month <b>JULY</b> Day <b>31</b> Year <b>1997</b>		3. Time of Death <b>10:30AM</b>	
4a. Facility Name (If not institution, give street and number) <b>7220 PARK HEIGHTS AVE., APT. B</b>			4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
5. Social Security Number <b>213-05-3722</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>89</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JULY 4, 1908</b>
9. Birthplace (State or Foreign Country) <b>MARYLAND</b>					
Usual Residence of Decedent					
10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>7220 PARK HEIGHTS AVE., APT. B</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>College</b>			
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BOOKKEEPER</b>		16b. Kind of Business/Industry <b>FOOD</b>			
17. Father's Name (First, Middle, Last) <b>BENJAMIN SAGEL</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>MIRIAM WITTRIAK</b>		
19a. Informant's Name/Relationship (Type, Print) <b>MAX KESSLER (SON)</b>			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7220 PARK HEIGHTS AVE., APT. B BALTO., MD 21208</b>		
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>SHAAREI ZION</b>		20c. Location - City or Town, State <b>8/1/97 ROSEDALE, MD</b>	
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 Reisterstown Rd Pikesville, MD 21208</b>			
23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Acute myocardial infarction</b> Due to (or as a consequence of): <b>b. Atherosclerotic cardiovascular disease 20 years</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Approximate Interval Between Onset and Death <b>minutes</b>					
23b. Part II: Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>23b. Did tobacco use contribute to the cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  <b>24a. Was an autopsy performed?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <b>24b. Were autopsy findings available prior to completion of cause of death?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier 		29c. License number <b>DO9775</b>		29d. Date signed (Month, Day, Year) <b>7/31/97</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stanley M. Rosen MD, 2435 W. Belvedere Ave., BALTO MD 21215</b>					
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours of death. This certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23515

ITEM# 20b PER F.H. FLM#750 8-5-97 J.A.

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FRANK A. KAUFMAN</b>				2. Date of Death Month <b>JULY</b> Day <b>31</b> Year <b>1997</b>		3. Time of Death <b>3 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>2516 STONE MILL RD.</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>217-26-2731</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>81</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>MAR. 4, 1916</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>2516 STONE MILL RD.</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) <b>5+</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SENIOR US DISTRICT JUDGE</b>		16b. Kind of Business/Industry <b>JUDICIAL</b>			
	17. Father's Name (First, Middle, Last) <b>NATHAN HESS KAUFMAN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>HILDA HECHT</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>CLEMENTINE KAUFMAN (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2516 STONE MILL RD. BALTIMORE, MD 21208</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HILLTOP SERV. CORP.</b>		Date <b>8/1/97</b> <b>7/31/97</b>		20c. Location - City or Town, State <b>TOWSON, MD</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Jay Alan Levi</i>				22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Refractory anemia</b> Due to (or as a consequence of):  b. <b>Myelodeplplontic syndrome</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death  <b>6 yrs</b>  <b>6 yrs</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
					24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Mark P. Zepher</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D12586</b>				29d. Date signed (Month, Day, Year) <b>7/31/97</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>10755 Falls Rd Lutherville MD 21093</b>				31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>Julia Davidson-Randall</i>				33. Registrar's Signature			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23516

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last) <b>Berta Calderon</b>		2. Date of Death Month <b>August</b> Day <b>2</b> Year <b>1997</b>		3. Time of Death <b>10:13 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>212-30-0606</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F <b>XX</b>		7. Age (In yrs. last birthday) <b>86</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>APR. 7, 1911</b>		9. Birthplace (State or Foreign Country) <b>YUGOSLAVIA</b>			
10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>6920 MARSUE DR., APT. 1-B</b>		10f. Zip Code <b>21215</b>	
10g. Citizen of What Country? <b>USA</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)	
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SEAMSTRESS</b>		16b. Kind of Business/Industry <b>CLOTHING</b>		17. Father's Name (First, Middle, Last) <b>DAVID PAPO</b>	
18. Mother's Name (First, Middle, Maiden Surname) <b>REGINA UNKNOWN</b>		19a. Informant's Name/Relationship (Type, Print) <b>MRS. FLORA FRIEDMAN (DAUG.)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9109 HOWARD SQ. DR. BALTIMORE, MD 21208</b>	
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>CHEVRA AHAVAS CHESED</b>		20c. Location - City or Town, State <b>8/4/97 RANDALLSTOWN, MD</b>	
21. Signature of Funeral Service Licensee <i>Michael Kugler</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  e. <b>Myocardial Infarction</b> Due to (or as a consequence of): b. <b>Coronary Artery Disease</b> Due to (or as a consequence of): c. <b>Atherosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): d.  Approximate Interval Between Onset and Death <b>30 min.</b> <b>10 yr.</b> <b>10 yr.</b>	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined	
28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Daniel R. Mahesh</i>		29c. License number <b>D33906</b>	
29d. Date signed (Month, Day, Year) <b>August 2, 1997</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>	
32. Registrar's Signature <i>Julia Paulson-Randall</i>					

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Medical or Attending Physician: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

1. The first part of the report is a general introduction to the subject.

2. The second part of the report is a detailed description of the methods used.

3. The third part of the report is a discussion of the results.

4. The fourth part of the report is a conclusion.

5.

6. The fifth part of the report is a list of references.

7. The sixth part of the report is a list of figures.

8. The seventh part of the report is a list of tables.

9. The eighth part of the report is a list of appendices.

10. The ninth part of the report is a list of footnotes.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23517

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ruth Karlner

2. Date of Death

08 04 97

3. Time of Death

0550

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

214-14-4275

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

FEB. 11, 1922

9. Birthplace (State or Foreign)

GERMANY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3501 CLARKS LANE, APT. 1-A

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

EMANUEL

SCHLOSSBERG

18. Mother's Name (First, Middle, Maiden Surname)

BLUEMA

NEUBURGER

19a. Informant's Name/Relationship (Type, Print)

MR. FRED SCHLOSSBERG (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3833 MENLO DRIVE BALTIMORE, MD 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHEVRA AHAVAS CHESED

Date

8-4-1997 RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

*Signature*

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.

8900 Reisterstown Rd Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Non-Hodgkins Lymphoma  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Respiratory Failure  
Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Signature*

29c. License number

29d. Date signed (Month, Day, Year)

08 04 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Justin G. Rosemore, DO 2401 Belvedere Ave Baltimore, MD 21215

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

*Signature*

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23518

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CAROLYN

SYLVIA

LAZARUS

2. Date of Death

Month

Day

Year

July 31, 1997

3. Time of Death

11:50pm

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

579-36-3503

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

JUNE 16, 1931

9. Birthplace (State or Foreign Country)

WASHINGTON, DC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2500 W. BELVEDERE AVE., APT. 212

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

EMPLOYEE

16b. Kind of Business/Industry

UNITED STATES NAVY

17. Father's Name (First, Middle, Last)

MEYER

N.

SCHIFF

18. Mother's Name (First, Middle, Maiden Surname)

ROSE

GOLDBERG

19a. Informant's Name/Relationship (Type, Print)

ARTHUR S. LAZARUS (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1203 TOWNSHIP LINE RD. PHOENIXVILLE, PA 19460

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEM. GARDENS

Date

8/3/97

20c. Location - City or Town, State

FALLS CHURCH, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

metastatic Colon Cancer

5 years

Due to (or as a consequence of):

b.

Breast Cancer

5 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Rong Zhang - Howard, MD.

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

Aug 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RONG ZHANG - HOWARD, Union Memorial Hospital, 201 E. University Parkway, Baltimore, MD

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Julia Robinson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CAROLYN LAZARUS  
Division of Vital Records, P.O. Box 68760,

JA



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23519

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Delmar Carl Lang

2. Date of Death

Month

Day

Year

3. Time of Death

0605

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

496-01-2038

6. Sex

XXM 2 ☐ F

7. Age (In yrs. last birthday)

80

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb 20,

1917

9. Birthplace (State or Foreign Country)

Toledo, OH

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Annapolis

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

524 Coover Road

10f. Zip Code

21401

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 42-65

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Military Officer

16b. Kind of Business/Industry

U.S. Air Force

17. Father's Name (First, Middle, Last)

Delmar Lang

18. Mother's Name (First, Middle, Maiden Surname)

Edith Freiman

19a. Informant's Name/Relationship (Type, Print)

Tessa W.B. Lang/Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

524 Coover Road, Annapolis, MD 21401

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Nat'l Cem. 8/7/97 Arlington, VA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Thomas J. Hardesty

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Coronary Artery Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive lung disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

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28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert B. Brown M.D.

29c. License number

1700561

29d. Date signed (Month, Day, Year)

Aug 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 Boston Rd. STE 300 Annapolis MD 21401

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23520

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Wilson Lanahan

2. Date of Death

Month  
AugustDay  
2ndYear  
1997

3. Time of Death

0735hrs.

4a. Facility Name (If not institution, give street and number)

ST- AGNES HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

215-07-0506

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 21, 1913

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Arbutus

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1225 Birch Avenue

10f. Zip Code

21227

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

meat packer

16b. Kind of Business/Industry

food

17. Father's Name (First, Middle, Last)

Luke J. Lanahan

18. Mother's Name (First, Middle, Maiden Surname)

Pauline Horelocker

19a. Informant's Name/Relationship (Type, Print)

Joyce M. Welsh, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6029 Claire Drive Elkridge, Maryland 21075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Pleasenthill Cemetery 8/5

Date

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

▶ [Signature]

22. Name and Address of Facility

Ambrose Funeral Home, Inc.

1328 Sulphur Spring Road

Arbutus

21227

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ASPIRATION PNEUMONIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CONGESTIVE HEART FAILURE

HYPERTENSION

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ [Signature] Resident Physician

29c. License number

P 11702

29d. Date signed (Month, Day, Year)

August 2nd 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: William Lanahan

Division of Vital Records, P.O. Box 68760,

0.5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23521

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS

LEDDON

2. Date of Death

Month Day Year  
AUGUST 2, 1997

3. Time of Death

8:22 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

218-48-1739

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

48

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 20 1948

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

HOWARD

10c. City, Town or Location

ELKRIDGE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6597 DEEP RUN PKWY

10f. Zip Code

21075

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

POLICE OFFICER

16b. Kind of Business/Industry

BALTIMORE CITY  
POLICE DEPT.

17. Father's Name (First, Middle, Last)

THOMAS J. LEDDON

18. Mother's Name (First, Middle, Maiden Surname)

FRANCES J. FONTZ

19a. Informant's Name/Relationship (Type, Print)

MICHELE SPARKLIN

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6530 DEEP RUN PKWY ELKRIDGE, MD 21075

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

NEW CATHEDRAL CEMETERY

Date

8/06/97

20c. Location - City or Town, State

BALTIMORE MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.  
4107 WILKENS AVE, BALTIMORE, MD 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

ACUTE MYOCARDIODIAL INFRACTION

Approximate  
Interval Between  
Onset and Death

6 HR

Immediate Cause (Final  
disease or condition  
resulting in death)e. Due to (or as a consequence of):  
CARDIOGENIC SHOCKSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D18406

29d. Date signed (Month, Day, Year)

8-2-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS MORRIS M.D., 7505 OSLER DR. SUITE 409, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23522

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Moore</b>				2. Date of Death Month Day Year <b>AUG 2, 1997</b>		3. Time of Death <b>5:00 PM</b>										
	4a. Facility Name (If not institution, give street and number) <b>Villa St. Michael</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>										
Funeral Director	5. Social Security Number <b>240-03-8440</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>DEC 4, 1914</b>										
	9. Birthplace (State or Foreign Country) <b>North Carolina</b>																
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No									
	10e. Street and Number <b>2840 W. Garrison Avenue</b>				10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>										
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Factory Worker</b>		16b. Kind of Business/Industry <b>Garment Industry</b>												
	17. Father's Name (First, Middle, Last) <b>Jasper Reeves</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Emma Daniels</b>												
	19a. Informant's Name/Relationship (Type, Print) <b>Brenda A. Williams/granddaughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2840 W. Garrison Ave. Baltimore, MD 21215</b>												
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 8/4/97</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>												
	21. Signature of Funeral Service Licensee <b>Edward A. Gregorchik</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>												
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td><b>Cerebral Thrombosis</b></td> <td rowspan="4">Approximate Interval Between Onset and Death <b>&gt; 1 year</b></td> </tr> <tr> <td>b.</td> <td></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a.	<b>Cerebral Thrombosis</b>	Approximate Interval Between Onset and Death <b>&gt; 1 year</b>	b.		c.		d.
Immediate Cause (Final disease or condition resulting in death)	a.	<b>Cerebral Thrombosis</b>	Approximate Interval Between Onset and Death <b>&gt; 1 year</b>														
	b.																
	c.																
	d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown																	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
		28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
		28f. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. Signature and title of certifier <b>Davidson</b> MD				29c. License number <b>D15872</b>		29d. Date signed (Month, Day, Year) <b>August 4 1997</b>											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Norwood Bog 7220 Park Heights 21208</b>																	
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>				32. Registrar's Signature <b>John Davidson-Randall</b>													

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23523

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Draper Moore

2. Date of Death

Month August 3, 1997

3. Time of Death

9:15 PM

4a. Facility Name (If not institution, give street and number)

Chesapeake Hospice House

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

577-32-1475

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

July 25, 1924 Rose Hill, Va

9. Birthplace (State or Foreign Country)

Rose Hill, Va

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Gambrills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

P.O. Box 812

10f. Zip Code

21054

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
if Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

4th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Maintenance

16b. Kind of Business/Industry

State of Maryland

17. Father's Name (First, Middle, Last)

William Edgar Moore

18. Mother's Name (First, Middle, Maiden Surname)

Emma Hounshell

19a. Informant's Name/Relationship (Type, Print)

Connie Elswick/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

790 Shelton Road, Crownsville, MD 21032

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Cemetery

Date

8/7/97

20c. Location - City or Town, State

Glen Burnie, MD

21. Signature of Funeral Service Licensee

Batal A. Arshad

22. Name and Address of Facility

Hardesty Funeral Home  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Recurrent Laryngeal Cancer

Due to (or as a consequence of):

Approximate interval Between Onset and Death

3 M

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice House

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Batal A. Arshad

29c. License number

D39505

29d. Date signed (Month, Day, Year)

Aug. 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YUDHISH MARKAN 1406-B CRAIN HWY #202 GLEN BURNIE, MD 21061

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

J. A. Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23524

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Catherine E. Marks				2. Date of Death Month Day Year Aug 4 1997		3. Time of Death 4:55 AM	
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare / Heritage				4b. City, Town, or Location of Death Dundalk		4c. County of Death Baltimore	
Funeral Director	5. Social Security Number 189-03-7084		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 84 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept 23 1912 Pa.	
	Usual Residence of Decedent		10e. State Md.		10b. County Baltimore		10c. City, Town or Location Dundalk	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 2416 Plainfield Rd		10f. Zip Code 21222		10g. Citizen of What Country? USA	
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Millworker		16b. Kind of Business/Industry Silk			
	17. Father's Name (First, Middle, Last) Richard Marks				18. Mother's Name (First, Middle, Maiden Surname) Jennie Cullan			
	19a. Informant's Name/Relationship (Type, Print) Catherine Weidow / niece				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2416 Plainfield Rd Dundalk, Md 21222			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Oak Lawn		Date 8-6-97		20c. Location - City or Town, State Hanover Township, Pa.	
	21. Signature of Funeral Service Licensee Anthony C. Connelly				22. Name and Address of Facility Connelly Funeral Home of Dundalk 7110 Sollers Point Rd 21222			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier Suejit Julka MD				29c. License number D 26 395		29d. Date signed (Month, Day, Year) 8/4/97		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Suejit Julka MD 2 MARKET PLACE DUNDALK 21222								
31. Date filed (Month, Day, Year) AUG 05 1997		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified in writing.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23525

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Carl E. McCabe Sr.</b>				2. Date of Death Month Day Year <b>JULY 30 1997</b>		3. Time of Death <b>18:29</b>	
	4a. Facility Name (If not institution, give street and number) <b>ST AGNES HOSP. 900 CATON AVE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>213-20-0415</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 5, 1926</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Lansdowne</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>3167 Kessler Road</b>				10f. Zip Code <b>21227</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> Collage (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>assembly worker</b>			16b. Kind of Business/Industry <b>auto</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Harry McCabe</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>Katie Fach</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Shirley McCabe, wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3167 Kessler Road Lansdowne, Maryland 21227</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Crestlawn Memorial</b>		20c. Location - City or Town, State <b>8/4/97 Sykesville, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Anbrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road 21227</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immadiata Cause (Final disease or condition resulting in death)  a. <b>myocardial infarction</b> Due to (or as a consequence of): b. <b>atherosclerotic cardiovascular disease</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							Approximate Interval Between Onset and Death <b>1 hour</b>  <b>unknown</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
State Registrar	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
29b. Signature and title of certifier 				29c. License number <b>D47353</b>		29d. Date signed (Month, Day, Year) <b>July 30 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jon Falck St-Agnes Hospital Catonsville, Maryland 21229</b>								
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

NAME: Carl McCabe

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23526

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CAROLYN MORRIS</b>				2. Date of Death Month <b>08</b> Day <b>02</b> Year <b>97</b>		3. Time of Death <b>9:20 A.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>RIDGEWAY MANOR NURSING HOME</b>				4b. City, Town, or Location of Death <b>CATONSVILLE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>214-38-7564</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>69</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>JUL 19, 1928</b>	9. Birthplace (State or Foreign Country) <b>SOUTH CAROLINA</b>
	10a. State <b>MD.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>4100 CRANSTON AVENUE</b>				10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>U.S. OF A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>UNKNOWN</b>				18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>NURSING ASSISTANT</b>		16b. Kind of Business/Industry <b>NURSING HOME</b>		
17. Father's Name (First, Middle, Last) <b>SHERMAN PEARSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MELVINA DINGLE</b>				
19a. Informant's Name/Relationship (Type, Print) <b>ALETHIA GATLIN (DAUGHTER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4100 CRANSTON AVENUE BALTIMORE, MD. 21229</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK 8/8/97</b>		Date <b>8/8/97</b>		20c. Location - City or Town, State <b>BALTO. BALTIMORE, MD. CO.</b>	
21. Signature of Funeral Service Licensee <i>Lewis T. Gwynn</i> <b>LEWIS T. GWYNN</b>				22. Name and Address of Facility <b>LEWIS T. GWYNN FUNERAL HOME 21215-6398</b> <b>4517 PARK HEIGHTS AVE. BALTO., MD.</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Hypertensive Arteriosclerotic Coronary Vascular Disease</b> Due to (or as a consequence of):  b. _____ Due to (or as a consequence of):  c. _____ Due to (or as a consequence of):  d. _____  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident - Subarachnoid hemorrhage</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		29b. Signature and title of certifier <i>Michael Schwartz</i>						
29c. License number <b>D19667</b>		29d. Date signed (Month, Day, Year) <b>2 August 1997</b>						
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Michael Schwartz MD 606 Harbourside Lane Boston, MA 02125</b>								
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>		32. Registrar's Signature <i>J. Davidson-Randall</i>						

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23527

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fannie Kathryn Meeker

2. Date of Death

August 1, 1997

Day Year

3. Time of Death

0100

4a. Facility Name (If not institution, give street and number)

ST. ELIZABETH'S NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-18-6129

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 17, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1011 ROCKHILL AVENUE

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

ELVIN HARE

18. Mother's Name (First, Middle, Maiden Surname)

ANNA BERGER

19a. Informant's Name/Relationship (Type, Print)

KAREN M. WELDEN (GRANDDAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1011 ROCKHILL AVENUE - BALTIMORE, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LORRAINE PARK CEMETERY

Date

8/4/97

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Dehydration

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Dysphagia

Due to (or as a consequence of):

Months

c. Chronic progressive dementia

Due to (or as a consequence of):

Yrs

d. Multi-stroke arteriosclerotic cerebrovascular disease

Yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 01786

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Laurence R. Gallagher MD 716 Maiden Choice Lane, Park, MA 01228

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23528  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD WEST MEINZ

2. Date of Death

August

Day

2

Year

1997

3. Time of Death

09:30 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL, 900 CATON AVENUE

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

078-14-6825

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

FEB 5 1924

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MD

10b. County

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1245 HAVERHILL ROAD

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ENGINEER

16b. Kind of Business/Industry

ELECTRONICS

17. Father's Name (First, Middle, Last)

HARRY W. MEINZ

18. Mother's Name (First, Middle, Maiden Surname)

JENNY WEDHAMS

19a. Informant's Name/Relationship (Type, Print)

GERLINDE R. MEINZ - WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1245 HAVERHILL ROAD, BALTIMORE, MD 21229

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

BALTIMORE NATIONAL

Date

AUG 5 97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

GARY L. KAUFMAN FUNERAL HOME  
AT MEADOWRIDGE MEMORIAL PARK

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

metastatic carcinoma tumor

Approximate Interval Between Onset and Death

12 mos

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D40850

29d. Date signed (Month, Day, Year)

August 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

YVONNE OTTAUANO MD 900 CATON AVE BALTIMORE MD 21229

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

NAME: Howard West Meinz



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23529

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rosalie S. Martelli

2. Date of Death

Month  
July

Day

30

Year

1997

3. Time of Death

23:15

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

166-03-0892

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

85

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)  
July 15, 1912

9. Birthplace (State or Foreign Country)

Sicily, Italy

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

641 West University Parkway

10f. Zip Code

21210

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry

Manufacturing

17. Father's Name (First, Middle, Last)

Gaspere Sorce

18. Mother's Name (First, Middle, Maiden Surname)

Camille Patti

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Simpson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

641 W. University Pkwy Baltimore, Maryland 21210

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Mary's Cemetery

Date

8/4/97

20c. Location - City or Town, State

Brier Creek Township, Pennsylvania

21. Signature of Funeral Service Licensee

Stacy Henss Carpenter

22. Name and Address of Facility

Burgee-Henss Funeral Home  
3631 Falls Road Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

2 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cardiovascular Disease

Due to (or as a consequence of):

3 years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy HTN, Diabetes

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. M. S. 10

29c. License number

A72438946-M17

29d. Date signed (Month, Day, Year)

July 30, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

PEIRING GAO, M.D. 201 E. University Blvd, Baltimore, MD 21218-2895

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Rosalie Martelli  
Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23530

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Charles Nichols, Jr.

2. Date of Death

August 2, 1997

3. Time of Death

12:50 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

225-12-8924

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 2, 1922

9. Birthplace (State or Foreign Country)

Omaha, NB

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1876 Aberdeen Circle

10f. Zip Code

21114-1648

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

43-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Officer

16b. Kind of Business/Industry

Security

17. Father's Name (First, Middle, Last)

George Hensley Nichols

18. Mother's Name (First, Middle, Maiden Surname)

Laura Louise Reise

19a. Informant's Name/Relationship (Type, Print)

Edith Nichols/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1876 Aberdeen Circle, Crofton, MD 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Lakemont Cemetery

Date

8/4/97

20c. Location - City or Town, State

Davidsonville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Hardesty Funeral Home, P.A.  
12 Ridgely Avenue, Annapolis, MD 21401

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Cardiac arrest

Due to (or as a consequence of):

b.

ASCVD (Atherosclerosis)

Due to (or as a consequence of):

c.

malnutrition

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

pernicious anemia  
subtotal gastrectomy  
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25134

29d. Date signed (Month, Day, Year)

08/5/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Carol Pressey MD, 1655 Crofton Blvd Crofton MD 21114/PO

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23531

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician /Medical Examiner

Funeral Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) WESLEY WALTER NELKER, Sr.				2. Date of Death Month: August Day: 2 Year: 1997		3. Time of Death 12:38 AM														
4a. Facility Name (If not institution, give street and number) BALTIMORE VETERAN AFFAIRS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE, MD		4c. County of Death N/A														
5. Social Security Number 212-16-4018		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) NOV 1, 1921	9. Birthplace (State or Foreign Country) Maryland													
Usual Residence of Decedent																				
10a. State MD		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No													
10a. Street and Number 2603 Woodland Avenue				10f. Zip Code 21215		10g. Citizen of What Country? USA														
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1943-45		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White														
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 9 College (1-4 or 5+) 9				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Locksmith		16b. Kind of Business/Industry Key Service														
17. Father's Name (First, Middle, Last) Walter Augustus Nelker				18. Mother's Name (First, Middle, Maiden Surname) Mildred Jarrett																
19a. Informant's Name/Relationship (Type, Print) Elizabeth A. Nelker/wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2603 Woodland Ave. Baltimore, MD 21215																
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory, Inc.		Date 8/2/97		20c. Location - City or Town, State Baltimore, MD														
21. Signature of Funeral Service Licensee Edward A. Gregorchik				22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228																
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td>HYPOXIA</td> <td>Approximate Interval Between Onset and Death 24 hours</td> </tr> <tr> <td>b.</td> <td>GASTROINTESTINAL BLEEDING</td> <td>24 hours</td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	HYPOXIA	Approximate Interval Between Onset and Death 24 hours	b.	GASTROINTESTINAL BLEEDING	24 hours	c.			d.		
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	HYPOXIA	Approximate Interval Between Onset and Death 24 hours																	
	b.	GASTROINTESTINAL BLEEDING	24 hours																	
	c.																			
	d.																			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown														
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No														
28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)																
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. Signature and title of certifier [Signature] MD				29c. License number P09707		29d. Date signed (Month, Day, Year) August 2, 1997														
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL SAMBAS, MD 10 NORTH GREENE STREET BALTIMORE, MARYLAND 21231																				
31. Date filed (Month, Day, Year) AUG 05 1997		32. Registrar's Signature [Signature]																		

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23532

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VERNON HENRY OTTO

2. Date of Death

August 2 1997

Day

Year

3. Time of Death

10:2 PM

4a. Facility Name (If not institution, give street and number)

FALLSTON GENERAL HOSPITAL

4b. City, Town, or Location of Death

FALLSTON

4c. County of Death

HARFORD

Funeral  
Director

5. Social Security Number

336 10 4236

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

MARCH 14, 1918

9. Birthplace (State or Foreign Country)

ILLINOIS

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HARFORD

10c. City, Town or Location

BELL AIR

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

413 LINWOOD AVE.

10f. Zip Code

21014

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YRS.

College (1-4 or 5+)

2 YRS.

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ELECTRICAL ENGINEER

16b. Kind of Business/Industry

R.T. &amp; T. CORPORATION

17. Father's Name (First, Middle, Last)

JOHN L. OTTO

18. Mother's Name (First, Middle, Maiden Surname)

EMMA PIPER

19a. Informant's Name/Relationship (Type, Print)

VIRGINIA M. OTTO

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

413 LINWOOD AVE BELL AIR, MARYLAND 21014

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

EVANS FUNERAL CHAPEL - BELL AIR, P.A.

Date

AUG. 7 1997

20c. Location - City or Town, State

FOREST HILL, MARYLAND

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

EVANS FUNERAL CHAPEL - BELL AIR, P.A. 21050  
3 NEWPORT DRIVE FOREST HILL, MARYLAND

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Myocardial Infarction

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

90 minutes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PROSTATE CANCER

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury et Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature] M.D.

29c. License number

D 40819

29d. Date signed (Month, Day, Year)

August 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARCO ZAMORA, M.D. 200 Milton Ave. Fallston Md 21047

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23533

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MORRIS

FRINER

2. Date of Death

Month Day Year  
AUG. 2, 1997

3. Time of Death

2:45 AM

4a. Facility Name (If not institution, give street and number)

1 GRISTMILL COURT #508

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

219-32-0995

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 16, 1913

9. Birthplace (State or Foreign Country)

RUSSIA

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

1 GRISTMILL COURT #508

10f. Zip Code

21208

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collega (1-4or 5+)

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REALTOR

16b. Kind of Business/Industry

REAL ESTATE

17. Father's Name (First, Middle, Last)

BORUCH

FRINER

18. Mother's Name (First, Middle, Maiden Surname)

ELKA

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

FREDA FRINER / WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1 GRISTMILL COURT #508 BALTIMORE, MD 21208

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BETH TFILOH

Date

8/3/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensed



22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 Reisterstown Rd Pikesville, MD 21208

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Septicemia and Metabolic Acidosis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. peripheral vascular Disease &amp; gangrene of foot

Due to (or as a consequence of):

c. Severe ASCVD and Atrial Fibrillation

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Marked Renal Insufficiency

Congestive Cardiac myopathy

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 No

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 No

25. Was case referred to medical examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

Other:

40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

20 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

008029

29d. Date signed (Month, Day, Year)

8/2/97

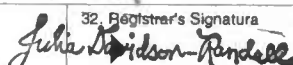
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

90 Painters Mill Rd. Owings Mill, Md 21117

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature



State Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital Attending Physician: The law requires that the death certificate be executed within 48 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23534  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) SEVASTI PSIROUKIS				2. Date of Death Month Day Year August 3, 1997		3. Time of Death 11:30 A.M.		
	4a. Facility Name (If not institution, give street and number) Genesis Eldercare Medical Center				4b. City, Town, or Location of Death Towson		4c. County of Death Baltimore		
Funeral Director	5. Social Security Number 211-01-4220		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 82 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 17, 1914	9. Birthplace (State or Foreign Country) Greece	
	Usual Residence of Decedent								
10a. State Maryland		10b. County N/A		10c. City, Town or Location Baltimore			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
10e. Street and Number 717 S. Broadway				10f. Zip Code 21231		10g. Citizen of What Country? U.S.A.			
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 6th College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Restaurateur			16b. Kind of Business/Industry Food		
17. Father's Name (First, Middle, Last) Pantelis Sirris				18. Mother's Name (First, Middle, Maiden Surname) Paraskevi Baha					
19a. Informant's Name/Relationship (Type, Print) Konstantine J. Prevas, Esquire				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 Brook Meadow Drive, Towson, Md. 21286					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) Greek Orthodox Cemetery		Date 8-6-97	20c. Location - City or Town, State Baltimore, Md.			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Matthews Funeral Home 3021 Eastern Ave., Baltimore, Md. 21224					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>Atherosclerotic Cardiovascular Disease</u> Due to (or as a consequence of):  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____									Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
			28d. Describe how injury occurred			28e. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier  M.D.			29c. License number D38708		29d. Date signed (Month, Day, Year) 8/4/97	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) SHELLEY M. CABELL, 4000010 Court Rd. Baltimore, MD 21208									
31. Date filed (Month, Day, Year) AUG 05 1997			32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

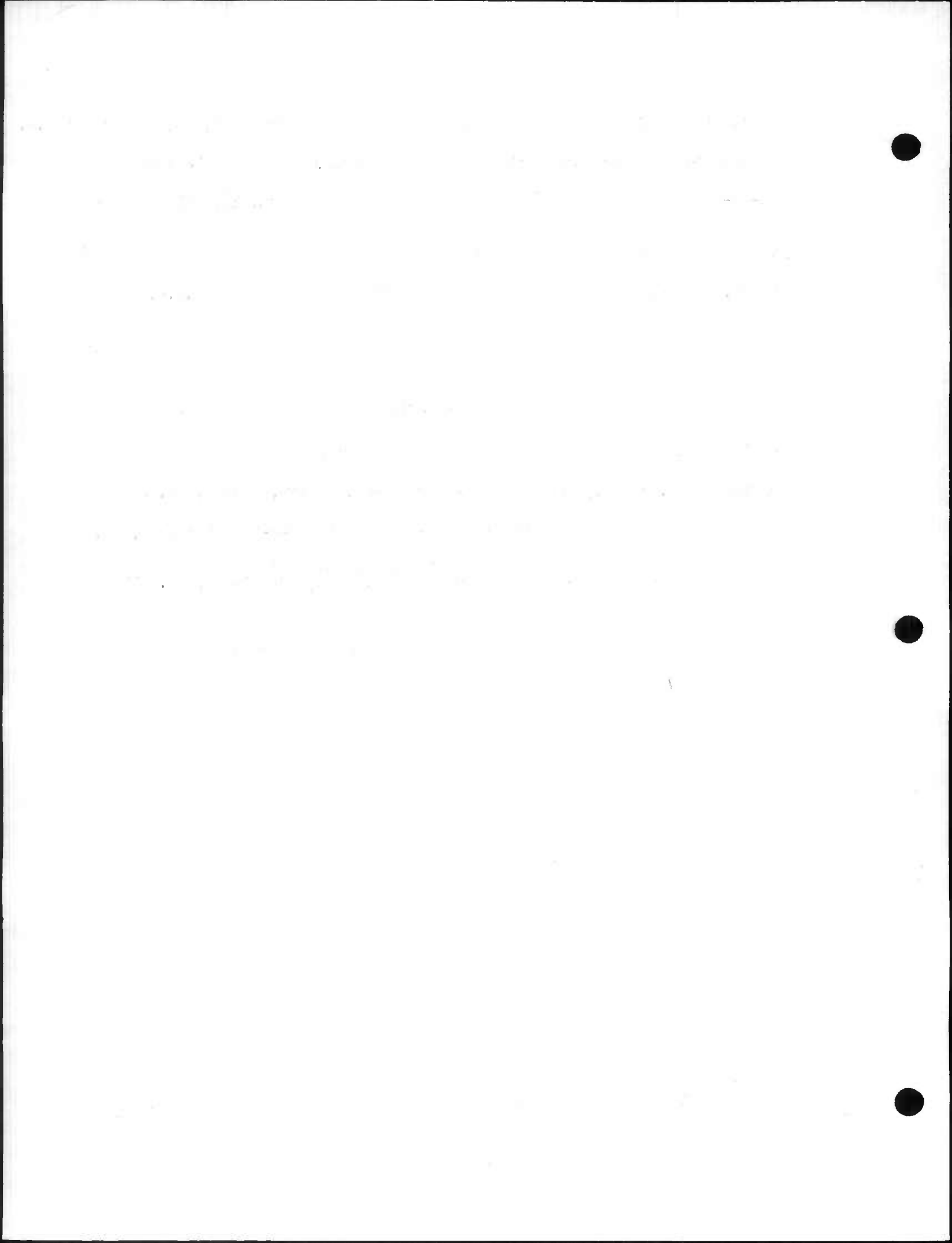
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23535

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Reininger

2. Date of Death  
Month Day Year

July 31 1997

3. Time of Death

11:45 pm

4a. Facility Name (If not institution, give street and number)

Carroll County General Hospital

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

215-16-6770

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

July 15, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

FL

10b. County

Sarasota

10c. City, Town or Location

North Port

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

481 Loma Linda

10f. Zip Code

34287

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Quality Control Inspector

16b. Kind of Business/Industry

General Motors

17. Father's Name (First, Middle, Last)

John Nicholas Reininger

18. Mother's Name (First, Middle, Maiden Surname)

Marie Birkenheier

19a. Informant's Name/Relationship (Type, Print)

Katherine N. Reininger/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

481 Loma Linda North Port, FL 34287

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory, Inc. 8/1/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Edward A. Gregorchik

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CVA  
Due to (or as a consequence of):

Approximate interval between Onset and Death

50 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Norman Goldstein

29c. License number

D26385

29d. Date signed (Month, Day, Year)

8/1/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Norman Goldstein 215 Washington Heights Westminister, MD

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23536

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Pearl E. Rothe

2. Date of Death

Month  
AUGUSTDay  
1,Year  
1997

3. Time of Death

9:30 A.M.

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

OLD COURT NURSING CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

5. Social Security Number

215-03-2925

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

AUG 03, 1905

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

REISTERSTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6205 DEER PARK ROAD

10f. Zip Code

21136

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7TH GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

JAMES L. WHALEN

18. Mother's Name (First, Middle, Maiden Surname)

LURA HARRY

19a. Informant's Name/Relationship (Type, Print)

THURMAN A. WHALEN (BROTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6205 DEER PARK ROAD - REISTERSTOWN, MD 21136

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

LOUDON PARK CEMETERY

Date

8/4/97

20c. Location - City or Town, State

BALTIMORE

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21227

23a. Part I. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Altersenotec cardiovascular disease*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Multifactorial Dementia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D25112

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. TAHOORA KAWAJA - 1777 REISTERSTOWN ROAD - SUITE 108-PIKESVILLE, MD 21208

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

*T. Kawaja*

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

PEARL E. ROTHE

to the Hospital or Attending Physician: The law requires that the death certificate be executed with 24 hours after death. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23537

ITEM#5&amp;9 PER F.H. FLM#G750 8/5/97 J.A. Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MILDRED</b>		2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>5:5 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>PIKESVILLE NURSING HOME</b>		4b. City, Town, or Location of Death <b>PIKESVILLE</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>212-03-8051</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>81</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JULY 18, 1916</b>		9. Birthplace (State or Foreign Country) <b>POLAND MARYLAND</b>		
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				
	10e. Street and Number <b>4004 FORDS LANE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>USA</b>
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESWOMAN</b>		16b. Kind of Business/Industry <b>DEPARTMENT STORE</b>
	17. Father's Name (First, Middle, Last) <b>ABRAHAM</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>TOBY</b>		<b>SCHEINBERG</b>
	19a. Informant's Name/Relationship (Type, Print) <b>MS NATALIE LEON (NIECE)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 WILD CHERRY CT. REISTERSTOWN, MD 21136</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BETH TFILOH</b>		Date <b>8/3/97</b>
	20c. Location - City or Town, State <b>BALTIMORE, MD</b>				
21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC.</b> <b>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic cardiovascular disease</b> Due to (or as a consequence of): <b>Ischemic</b>				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Emphysema</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				
	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier 		29c. License number <b>D15572</b>		29d. Date signed (Month, Day, Year) <b>August 1, 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HAROLD BOB 25 Main St. Reisterstown, Md. 21136-1215</b>					
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23538  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CORRINE SMITH

2. Date of Death

Month

Day

Year

08

02

97

3. Time of Death

0030

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-16-0717

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

11/11/23

9. Birthplace (State or Foreign Country)

USA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town, or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4518 Mandorene RD

10f. Zip Code

21229

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (8-12)

College (1-4 or 5+)

Unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Domestic

16b. Kind of Business/Industry

Homos

17. Father's Name (First, Middle, Last)

George Scott

18. Mother's Name (First, Middle, Maiden Surname)

Sarah J. Brown

19a. Informant's Name/Relationship (Type, Print)

Dorothy M Harris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1218 N. Augusta Ave

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial

Date

8/8/97

20c. Location - City or Town, State

Randallstown MD

21. Signature of Funeral Service Licensee

Vaughn C. Hume

22. Name and Address of Facility

Albert P. Wythe F/H PA.

638 N. Gilmore St BALTO MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Adult Respiratory Distress Syndrome

Due to (or as a consequence of):

b. Sepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Colon Carcinoma

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident5 ☐ Pending investigation 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Stewart

29c. License number

P10249

29d. Date signed (Month, Day, Year)

August 02, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DYLAN STEWART, M.D. UNIVERSITY OF MARYLAND MEDICAL CENTER

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97-4149-003

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ROY Items: 23a part I, 27, 28a-f per ME0 G-750 8/26/97 dn  
SEABOLTState of Maryland / Department of Health and Mental Hygiene  
Certificate of Death

97 23539

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Roy James Seabolt</b>				2. Date of Death Month Day Year <b>JULY 25 1997</b>		3. Time of Death <b>5:30 P.M.</b>																				
	4a. Facility Name (If not institution, give street and number) <b>7912 HEATHERMIST DRIVE</b>				4b. City, Town, or Location of Death <b>SEVERN</b>		4c. County of Death <b>ANNE ARUNDEL</b>																				
Funeral Director	5. Social Security Number <b>236-92-6777</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>37</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>OCT 11, 1959</b>	9. Birthplace (State or Foreign Country) <b>West Virginia</b>																			
	Usual Residence of Decedent																										
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Severn</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No																					
	10e. Street and Number <b>7912 Heathermist Drive</b>				10f. Zip Code <b>21144</b>		10g. Citizen of What Country? <b>USA</b>																				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>UNK.</b>		16b. Kind of Business/Industry <b>Credit Union</b>																						
	17. Father's Name (First, Middle, Last) <b>Amos Seabolt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Francis Larch</b>																						
	19a. Informant's Name/Relationship (Type, Print) <b>Betty M. Hays/sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Route 1 Box 143-B Cottageville, WV 25239</b>																						
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 8/5/97</b>		Date <b>8/5/97</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>																				
	21. Signature of Funeral Service Licensee  <b>Edward A. Gregorchik</b>				22. Name and Address of Facility <b>Cremation Society of Maryland, Inc. 299 Frederick Rd. Baltimore, MD 21228</b>																						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																										
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <b>AMITRIPTYLINE INTOXICATION</b></td> <td rowspan="4">Due to (or as a consequence of):</td> </tr> <tr> <td>b. _____</td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <b>AMITRIPTYLINE INTOXICATION</b>	Due to (or as a consequence of):	b. _____	c. _____	d. _____													
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<table border="1"> <tr> <td colspan="4">29d. Date signed (Month, Day, Year) <b>JULY 26, 1997</b></td> <td colspan="4">30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b></td> </tr> <tr> <td colspan="4">31. Date filed (Month, Day, Year) <b>AUG 05 1997</b></td> <td colspan="4">32. Registrar's Signature </td> </tr> </table>								29d. Date signed (Month, Day, Year) <b>JULY 26, 1997</b>				30. Name and address of person who completed causa of death (Item 23e) (Type, Print) <b>DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>				32. Registrar's Signature 							
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31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>				32. Registrar's Signature 																							

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23540

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John Franklin SILBERZAHN</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>7:01 P.M.</b>				
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>				
Funeral Director	5. Social Security Number <b>213 09 9448</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Sept. 5, 1914</b>				
	Usual Residence of Decedent		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>								
To Be Completed by Funeral Director	10a. State <b>GEORGIA</b>		10b. County <b>GWINNETT</b>		10c. City, Town or Location <b>Dacula</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>2241 Lammie Wages Road</b>				10f. Zip Code <b>30019</b>		10g. Citizen of What Country? <b>U.S.A.</b>				
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>W.W.II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YRS.</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>BAKER</b>			16b. Kind of Business/Industry <b>HAUSWALD'S BAKING CO.</b>			
	17. Father's Name (First, Middle, Last) <b>JOHN A. SILBERZAHN</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY M. ALLEN</b>						
	19a. Informant's Name/Relationship (Type, Print) <b>SHARON L. OSBORNE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2241 Lammie Wages Road Dacula, Georgia 30019</b>						
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MORELAND MEMORIAL PARK</b>		Date <b>AUG. 4, 1997</b>		20c. Location - City or Town, State <b>PARKVILLE, MARYLAND</b>				
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>EVANS CHAPEL OF MEMORIES 8800 HARFORD ROAD - PARKVILLE, MARYLAND</b>						
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Acute myocardial infarction</b> Due to (or as a consequence of):  b. <b>Coronary artery disease</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>1 day</b>		
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b>								23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29e. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier 				29c. License number <b>R D 2330</b>		29d. Date signed (Month, Day, Year) <b>August 1, 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Brian Knop 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>											
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>				32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23541

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) MARY LOU SAYRE				2. Date of Death Month Day Year JULY 23 1997				3. Time of Death 12:15 PM		
	4a. Facility Name (If not institution, give street and number) 8204 JONNIE LANE				4b. City, Town, or Location of Death GAITHERSBURG				4c. County of Death MONTGOMERY		
Funeral Director	5. Social Security Number 401-30-2492		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 70 Yrs.		8. Date of Birth (Month, Day, Year) MAY 7, 1927		9. Birthplace (State or Foreign Country) KENTUCKY		
	Usual Residence of Decedent										
To Be Completed by Funeral Director	10a. State MARYLAND		10b. County MONTGOMERY		10c. City, Town or Location GAITHERSBURG				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
	10e. Street and Number 8204 JONNIE LANE				10f. Zip Code 20882		10g. Citizen of What Country? UNITED STATES				
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: WHITE			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) PERSONNEL MANAGER				18b. Kind of Business/Industry RETAIL		
	17. Father's Name (First, Middle, Last) ELMER DENNEY				18. Mother's Name (First, Middle, Maiden Surname) MARY GAINES						
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) JANICE A. FITTS/ DAUGHTER				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 5308, LAYTONSVILLE, MARYLAND 20882						
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) NATIONAL MEMORIAL PARK		Date 7/26/97		20c. Location - City or Town, State FALLS CHURCH, VIRGINIA		
	21. Signature of Funeral Service Licensee Roy W. Barber				22. Name and Address of Facility MURIEL H. BARBER FUNERAL HOME P.O. BOX 5038, LAYTONSVILLE, MARYLAND 20882						
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. e. Small Cell Lung Cancer Due to (or as a consequence of):										
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No											
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. Signature and title of certifier Kenneth Miller, MD				29c. License number 033686				29d. Date signed (Month, Day, Year) July 25, 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Kenneth Miller, MD 1811 Prince Philip Dr, Chevy, MD											
31. Date filed (Month, Day, Year) AUG 05 1997				32. Registrar's Signature Julia Davidson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23542

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HAROLD S TABB</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>10:05 PM</b>		
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>213-28-7731</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>68</b> Yrs.		8. Date of Birth Month <b>DEC</b> Day <b>19</b> Year <b>1928</b>		
	9. Birthplace (State or Foreign Country) <b>MD</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent									
10a. State <b>MD</b>			10b. County <b>N/A</b>			10c. City, Town or Location <b>BALTIMORE</b>			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>6316 GREENSPRING AVE, APT T3</b>			10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:			13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			
14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)			16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALESMAN</b>			
17. Father's Name (First, Middle, Last) <b>SAMUEL TABB</b>			18. Mother's Name (First, Middle, Maiden Surname) <b>SOPHIE TERKOWITZ</b>			19. Informant's Name/Relationship (Type, Print) <b>STUART M. TABB (SON)</b>			
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3228 SHELburne RD; BALTIMORE, MD 21208</b>			20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW YOUNG MEN</b>			
20c. Location - City or Town, State <b>8/3/1997 BALTIMORE, MD</b>			21. Signature of Funeral Service Licensee <i>Joel D Lewis</i>			22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 REISTERSTOWN RD; PIKESVILLE, MD 21208</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Colon Cancer</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  <b>Coronary artery disease</b> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>several months</b>									
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>Coronary artery disease</b>									
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown									
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined									
28a. Date of Injury (Month, Day Year) <b>August 1, 1997</b>									
28b. Time of Injury <b>M</b>									
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No									
28d. Describe how injury occurred									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)									
28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Michael H. [Signature]</i>									
29c. License number <b>D-40521</b>									
29d. Date signed (Month, Day, Year) <b>August 1, 1997</b>									
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>5401 Old Court Road Randallstown MD 21133</b>									
31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>									
32. Registrar's Signature <i>Julia Davidson-Randall</i>									

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or item 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23543

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Agnes Virginia Todd				2. Date of Death Month Day Year August 3 1997		3. Time of Death 12 18 PM		
	4a. Facility Name (If not institution, give street and number) North Arundel Hospital Association Glen Burnie				4b. City, Town, or Location of Death Anne Arundel		4c. County of Death Anne Arundel		
Funeral Director	5. Social Security Number 218-28-3287		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 81 Yrs.		8. Date of Birth (Month, Day, Year) Nov 29, 1915		
	9. Birthplace (State or Foreign Country) Waterbury, MD		10a. State MD		10b. County Anne Arundel		10c. City, Town or Location Crownsville		
Usual Residence of Decedent		10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1016 Generals Highway		10f. Zip Code 21032		10g. Citizen of What Country? U.S.A.	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Nurse		16b. Kind of Business/Industry Medical					
17. Father's Name (First, Middle, Last) Mahlon Lowman				18. Mother's Name (First, Middle, Maiden Surname) Rosa Marie Lowman					
19a. Informant's Name/Relationship (Type, Print) Betty Jane Crane/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1008 Joyce Drive, Crownsville, MD 21032					
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Baldwin Memorial		Date 8/5/97		20c. Location - City or Town, State Millersville, MD			
21. Signature of Funeral Service Licensee [Signature]				22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401					
23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Due to (or as a consequence of): Arteriosclerotic Heart Disease Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Renal Failure Insulin Dependent Diabetes Mellitus		Approximate Interval Between Onset and Death Days Years							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Insulin Dependent Diabetes Mellitus				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown					
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and Title of certifier [Signature]		29c. License number D15860		29d. Date signed (Month, Day, Year) August 3 1997			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Hilary O'Herrity MD 335 Hospital Drive Glen Burnie Md.		31. Date filed (Month, Day, Year) AUG 05 1997							

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician /Medical Examiner

Funeral Director

Agnes V Todd

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23544

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) LILLIAN M THOMAS 2. Date of Death Aug 01 97 3. Time of Death 1857

Funeral  
Director

4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel

5. Social Security Number 579-07-6184 6. Sex ☐ M ☒ F 7. Age (In yrs. last birthday) 80 Yrs. 8. Date of Birth (Month, Day, Year) Mar. 9, 1917 9. Birthplace (State or Foreign Country) Washington D.C.

Usual Residence of Decedent 10a. State Maryland 10b. County Anne Arundel 10c. City, Town or Location Annapolis 10d. Inside City Limits ☐ Yes ☒ No

10e. Street and Number 130 Hearne Road 10f. Zip Code 21401 10g. Citizen of What Country? United States

11. Marital Status ☐ Never Married ☐ Married ☒ Widowed ☐ Divorced 12. Was Decedent Ever in U.S. Armed Forces? ☐ Yes ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ Yes ☒ No Specify: 14. Race - American Indian, Black, White, etc. Specify: White

15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11 College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker 16b. Kind of Business/Industry Own Home

17. Father's Name (First, Middle, Last) William Whipple Campbell 18. Mother's Name (First, Middle, Maiden Surname) Hilda Marie Mayer

19a. Informant's Name/Relationship (Type, Print) Shela Thompson/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Catrina Lane Annapolis, MD 21403

20a. Method of Disposition ☐ Burial ☒ Cremation ☐ Removal from State ☐ Donation ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Metro Crematory Date Aug. 4, 1997 20c. Location - City or Town, State Catonsville, MD

21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory insufficiency COPD Due to (or as a consequence of): a. b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last {

Approximate Interval Between Onset and Death 48h - year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HASCO

23b. Did tobacco use contribute to the cause of death? ☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed? ☒ Yes ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ☐ Yes ☒ No

25. Was case referred to medical examiner? ☒ Yes ☐ No 26. Place of Death (Check only one) Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death ☒ Natural ☐ Accident ☐ Suicide ☐ Homicide ☐ Pending investigation ☐ Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? ☐ Yes ☐ No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier [Signature] 29c. License number D21438 29d. Date signed (Month, Day, Year) Aug 01 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL J. GABRIEL M. GORRINGE 4145 STE 120 ANNAPOLIS MD 21401

State  
Registrar

31. Date filed (Month, Day, Year) AUG 05 1997

32. Registrar's Signature [Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23545

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALFRED

2. Date of Death

TAYLOR, SR.

JULY 31, 1997

3. Time of Death

9:20 PM

4e. Facility Name (If not institution, give street and number)

MARYLAND GENERAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-12-0240

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MAY 18, 1920

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1413 E. PRESTON STREET

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: NEGRO

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

ROOFER

16b. Kind of Business/Industry

PRIVATE CONTRACTOR

17. Father's Name (First, Middle, Last)

William Taylor

18. Mother's Name (First, Middle, Maiden Surname)

ELLA JONES

19a. Informant's Name/Relationship (Type, Print)

THOMASINE E. HARRISON-DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

302 S. MASON COURT BALTO, MD. 21231

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

BALTIMORE CEMETERY AUG. 8, 1997

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTIMORE MARYLAND 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Ischemic Cardiomyopathy

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebro Vascular Accident

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Vipul Kumar Bhalodiya

29c. License number

89257

29d. Date signed (Month, Day, Year)

7/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Vipul Kumar Bhalodiya, M.D. c/o Maryland General Hospital.

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Kaidon-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23546

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STANLEY HUETT TANSEY

2. Date of Death

Month July Day 30 Year 97

3. Time of Death

7:35 p.m.

4a. Facility Name (If not institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

041-28-0111

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
OCT 8, 1903

9. Birthplace (State or Foreign Country)

NEW LONDON, CONN.

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

719 MAIDEN CHOICE LANE - HR-422

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12TH GRADE

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

DEPUTY CHIEF

16b. Kind of Business/Industry

FIRE--DEPARTMENT

17. Father's Name (First, Middle, Last)

JOHN TANSEY

18. Mother's Name (First, Middle, Maiden Surname)

ROSE HUETT

19a. Informant's Name/Relationship (Type, Print)

MILDRED E. TANSEY (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

719 MAIDEN CHOICE LANE -HR-422-CATONSVILLE, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CARROLL CREMATION SERVICES

Date

8/4/97

20c. Location - City or Town, State

HAMPSTEAD, MD

21. Signature of Funeral Service Licensee

J. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME INC.

4107 WILKENS AVENUE-BALTIMORE, MD

21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. End stage Dementia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prostate Cancer

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andres Salazar MD

29c. License number

D 51051

29d. Date signed (Month, Day, Year)

July 31 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andres Salazar 711 Maiden Choice Lane, Catonsville, MD, 21228

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

J. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME: Stanley Tansey

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23547

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George A. Wilkins, SR.

2. Date of Death

Month Day Year  
August 2 1997

3. Time of Death

3:50AM

4a. Facility Name (If not institution, give street and number)

Baltimore Veterans Administration

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

242-24-4249

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
DEC. 26, 1919

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1314 N. KENWOOD AVENUE

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: NEGRO

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9TH

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working

life. DO NOT use retired)

SELF EMPLOYED

16b. Kind of Business/Industry

BARBER

17. Father's Name (First, Middle, Last)

BENJAMIN WILKINS

18. Mother's Name (First, Middle, Maiden Surname)

VIRGINIA CARTER

19a. Informant's Name/Relationship (Type, Print)

ALLEN D. WILKINS -SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4A FORTNUM CT. RANDALLSTOWN, MD. 21133

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

GARRISON FOREST VET. CEM.

Date

AUG 2, 1997

20c. Location - City or Town, State

OWINGS MILLS, MD.

21. Signature of Funeral Service Licensee

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Respiratory Failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Adam Clark MD

29c. License number

VA number 13-10438 August 2, 1997

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Adam Clark

10 North Greene Street

31. Date filed (Month, Day, Year)

AUG 05 1997

32. Registrar's Signature

Lisa Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Reg. No.

97 23548

1. Decedent's Name (First, Middle, Last) Clarence I Wolf Jr. 2. Date of Death Month Day Year July 31, 1997 3. Time of Death 9:53 A.M. 4a. Facility Name (If not institution, give street and number) 541 Woodside Rd. 4b. City, Town, or Location of Death Pikesville 4c. County of Death Baltimore 5. Social Security Number 218-03-2510 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) 77 8. Date of Birth (Month, Day, Year) Jan. 24, 1920 9. Birthplace (State or Foreign Country) Maryland 10a. State Maryland 10b. County Baltimore 10c. City, Town or Location Pikesville 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 541 Woodside Rd. 10f. Zip Code 21208 10g. Citizen of What Country? U.S.A. 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No) 1 Yes 2 No 14. Race - American Indian, Black, White, etc. White 15. Decedent's Education (Specify only highest grade completed) 12 Years 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Roofing & Sheet Metal Cont. 16b. Kind of Business/Industry Korb Roofers 17. Father's Name (First, Middle, Last) Clarence I. Wolf, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Blanche M. Consor 19a. Informant's Name/Relationship (Type, Print) Evelyn Wolf (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 541 Woodside Rd. Pikesville, MD 21208 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery 20c. Location - City or Town, State Aug 4, Woodlawn, Maryland 21. Signature of Funeral Service Licensee [Signature] 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Lung Cancer Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last { 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical examiner? 1 Yes 2 No 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier [Signature] 29c. License number D35606 29d. Date signed (Month, Day, Year) 7/31/97 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Samuel H. Byers, Jr. 31. Date filed (Month, Day, Year) AUG 05 1997



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23549

ITEM#20b PER F.H. FLM#G750 8/5/97 J.A.

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROSALIE G. WOLANSKI</b>		2. Date of Death Month <b>AUG. 2</b> , Day <b>1997</b> , Year <b>1997</b>		3. Time of Death <b>10:07 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>SINAI HOSPITAL</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>
Funeral Director	5. Social Security Number <b>219-10-9384</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>71</b> Yrs.	8. Date of Birth (Month, Day, Year) <b>MAY 27, 1926</b>	9. Birthplace (State or Foreign Country) <b>MD</b>
	Usual Residence of Decedent				
To Be Completed by Funeral Director	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>7376 PARK VILLAGE COURT</b>		10f. Zip Code <b>21208</b>		10g. Citizen of What Country? <b>U.S.A.</b>
To Be Completed by Physician/Medical Examiner	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>Collegia (1-4 or 5+)</b>		
To Be Completed by Physician/Medical Examiner	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOMEMAKER</b>		16b. Kind of Business/Industry <b>OWN HOME</b>		
	17. Father's Name (First, Middle, Last) <b>SAMUEL GOLD</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ANNA SIMON</b>		
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>JOSEPH WOLANSKI/ HUSBAND</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7376 PARK VILLAGE COURT BALTIMORE, MD 21208</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP</b>		20c. Location - City or Town, State <b>8/3/97 BALTIMORE, MD</b>
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Michael Kruger</i>		22. Name and Address of Facility <b>SOL LEVINSON &amp; BROS., INC. 8900 Reisterstown Rd Pikesville, MD 21208</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>cerebral edema</b> Due to (or as a consequence of): b. <b>left hemisphere - cerebral infarction</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day Year) <b>8/3/97</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <i>Louis W Miller MD</i>		29c. License number <b>DO7421</b>		29d. Date signed (Month, Day, Year) <b>8/2/97</b>
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Louis W Miller 1838 Greentree Rd #300 Balt. Md. 21208</b>				
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>AUG 05 1997</b>		32. Registrar's Signature <i>Julia Davidson-Randall</i>		
	State Registrar				

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23550

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances R. Ambrose</b>				2. Date of Death Month <b>July</b> Day <b>31</b> Year <b>1997</b>		3. Time of Death <b>4:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>2304 Brohawn Avenue</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>216 26 7912</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>76</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 3, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2304 Brohawn Avenue</b>		10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>William Kelley</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Grace Thompson</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Ronald Sheldon / Grandson</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2304 Brohawn Avenue Baltimore, Maryland 21230</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		20c. Location - City or Town, State <b>8/4/97 Glen Burnie, Maryland</b>			
	21. Signature of Funeral Service Licensee <i>Jerome Francisco</i>		22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CHOLANGIO CARCINOMA WITH</b> Due to (or as a consequence of): <b>b. LIVER METASTASIS</b> Due to (or as a consequence of): <b>c. PULMONARY EMBOLISM</b> Due to (or as a consequence of): <b>d. DEEP VENOUS THROMBOSIS</b>							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Physician /Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined							
To Be Completed by Physician/Medical Examiner	28a. Date of Injury (Month, Day Year)		28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>Raymundo Caparros M.D.</i>		29c. License number <b>D 41284</b>		29d. Date signed (Month, Day, Year) <b>08/01/97</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>RAYMUNDO I. CAPARROS, M.D. 300 HOSPITAL DR., GLEN BURNIE, MD</b>							
	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <i>John Davidson-Rodriguez</i>					

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for filing as the burial-transit certificate.

3

[illegible]

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State of Maryland / Department of Health and Mental Hygiene

97 23551

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

EVELYN LAURA AKEHURST

2. Date of Death

Month  
08Day  
03Year  
'97

3. Time of Death

6:30 AM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

BEL FOREST NURSING &amp; REHAB. CENTER

4b. City, Town, or Location of Death

FOREST HILL

4c. County of Death

HARFORD

5. Social Security Number

213 18 1058

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Jan. 19, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Forest Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

109 Forest Valley Drive

10f. Zip Code

21050

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Graham Harman

18. Mother's Name (First, Middle, Maiden Surname)

Anna Coonan

19a. Informant's Name/Relationship (Type, Print)

M. Denise Sappington

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

900 Broadway Bel Air, Maryland 21014

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

8/6/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

DEMENTIA

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D20136

29d. Date signed (Month, Day, Year)

8-4-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. David Dunn

1311 Belair Road

Bel Air, Maryland 21014

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

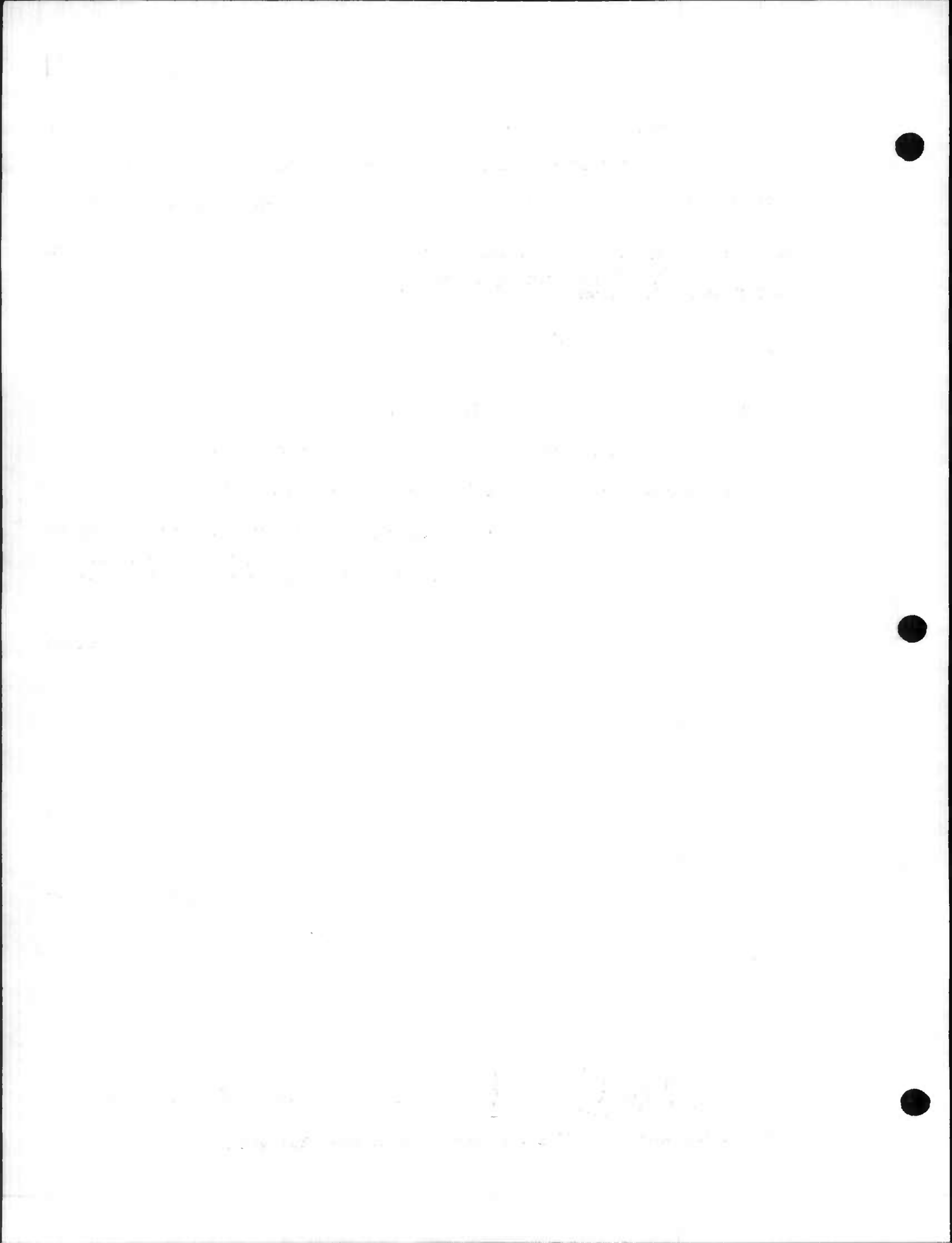
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 23552

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Henry

Buck

2. Date of Death  
Month Day Year  
August 5 19973. Time of Death  
10:40AMFuneral  
Director

4a. Facility Name (If not institution, give street and number)

Joseph Ritchey Hospice Nursing Ctn.

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

5. Social Security Number

219-40-4209

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

53 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
09-02-43

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1812 Ramsay Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9th Grade

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Kitchen Helper

16b. Kind of Business/Industry

Restaurant

17. Father's Name (First, Middle, Last)

Henry William Buck

18. Mother's Name (First, Middle, Maiden Summa)

Gladys G. Carter

19a. Informant's Name/Relationship (Type, Print)

Marvin Lester Buck

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1812 Ramsay Street Baltimore, Maryland 21223

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Gardens 08-08-97 Dundalk, Md.

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licenses

22. Name and Address of Facility

Baltimore, Maryland 21202  
WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ESOPHAGEAL CARCINOMA WITH METASTASES

9 Months

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) HOSPICE

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD.

29c. License number

D 06933

29d. Date signed (Month, Day, Year)

August 5 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOHN B. MACGIBSON MD. 101 W READ ST. SUITE 719 BALTIMORE MD.

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

EXPERIMENTAL  
The first part of the experiment was to determine the effect of the concentration of the solution on the rate of reaction. The concentration of the solution was varied from 0.1 M to 0.5 M. The rate of reaction was measured by the time taken for the reaction to complete. The results are shown in the following table.

TABLE I  
Rate of reaction vs. concentration of solution

Concentration of solution (M)

Concentration of solution (M)	Rate of reaction (s)
0.1	120
0.2	60
0.3	40
0.4	30
0.5	24

From the above table, it can be seen that the rate of reaction decreases as the concentration of the solution increases. This is because the rate of reaction is inversely proportional to the concentration of the solution.

EXPERIMENTAL  
The second part of the experiment was to determine the effect of the temperature on the rate of reaction. The temperature was varied from 20°C to 40°C. The rate of reaction was measured by the time taken for the reaction to complete. The results are shown in the following table.

TABLE II  
Rate of reaction vs. temperature

Temperature (°C)

Temperature (°C)	Rate of reaction (s)
20	120
30	60
40	30

From the above table, it can be seen that the rate of reaction decreases as the temperature increases. This is because the rate of reaction is inversely proportional to the temperature.

CONCLUSION  
The results of the experiment show that the rate of reaction is inversely proportional to the concentration of the solution and the temperature. This is because the rate of reaction is determined by the number of collisions between the reactant molecules, which is affected by both concentration and temperature.

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State of Maryland / Department of Health and Mental Hygiene

97 23553

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vivian I. Brennan

2. Date of Death

August 5 1997

3. Time of Death

12:36 AM

4a. Facility Name (If not institution, give street and number)

Doctors' Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

5. Social Security Number

025 14 4450

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 31, 1922

9. Birthplace (State or Foreign Country)

Massachusetts

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2613 Kimble Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

County Government

17. Father's Name (First, Middle, Last)

Anton W. Anderson

18. Mother's Name (First, Middle, Maiden Surname)

Anna Hendrickson

19a. Informant's Name/Relationship (Type, Print)

Thomas L. Brennan Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2613 Kimble Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oak Grove Cemetery

Date

August 9, 1997

20c. Location - City or Town, State

Vineyard Haven MA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Maryland 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Hypoxemia due to a.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular accident

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D43446

29d. Date signed (Month, Day, Year)

8.5.97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROUNTAN FARAHIFAR M.D. 4000 Mitchellville road 15216 Bowie MD 20716

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: This certificate must be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23554

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN K. BURLAGA

2. Date of Death

August 2, 1997

3. Time of Death

6:30am

4a. Facility Name (If not institution, give street and number)

CROFTON CONVALESCENT CENTER

4b. City, Town, or Location of Death

CROFTON

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

398 14 2275

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Aug. 29, 1917

9. Birthplace (State or Foreign Country)

Wisconsin

Usual Residence of Decedent

10a. State

Md

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1328 Dickey Drive

10f. Zip Code

21035

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

IGNATIAUS PLACHTA

18. Mother's Name (First, Middle, Maiden Surname)

CATHERINE DVORK

19a. Informant's Name/Relationship (Type, Print)

LEONARD BURLAGA/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS 10e

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ST. FRANCIS CEMETERY

Date

AUG. 6, 1997 Superior, WI.

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael J. Big Lee

22. Name and Address of Facility

ROBERT E. EVANS FUNERAL HOME INC, 16000

ANNAPOLIS RD., BOWIE, MD. 20715

23a. Pertinent. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)e. *Cardiopulmonary Arrest*

Due to (or as a consequence of):

b. *ASCVD*

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diabetes Mellitus*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

*1055 Crofton Blvd**Crofton, MD 21114*

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

*John Davidson*

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23555

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Mae Brown

2. Date of Death

Month August Day 1, Year 1997

3. Time of Death

11:45pm

4a. Facility Name (If not institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

212-74-9727

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 19, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Cockeysville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2 Nutmeg Knoll Ct. Apt. A

10f. Zip Code

21030

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Unknown

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Clarence Edward Crowl

18. Mother's Name (First, Middle, Maiden Surname)

Mary Louise Ohr

19a. Informant's Name/Relationship (Type, Print)

Doris B. Wilson/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 Nutmeg Knoll Ct. Apt A Cockeysville, MD 21030

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Memorial Gardens

Date

AUG. 5, 1997

20c. Location - City or Town, State

Timonium, Maryland

21. Signature of Funeral Service Licensee

Michael J. Flagle

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley Inc.  
10 West Padonia Road Timonium, MD 21093

23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Heart Disease

Due to (or as a consequence of):

b. Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. J. Alan Baldanza

29c. License number

D19146

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. J. Alan Baldanza, M.D. 10629 York Road Cockeysville, MD 21030

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital/Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23556

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SEARS THOMAS BOYD

2. Date of Death

Month Day Year  
AUGUST 02 1997

3. Time of Death

07:13PM

4a. Facility Name (If not institution, give street and number)

THE JOHNS HOPKINS HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

5. Social Security Number

225-16-7679

6. Sex

XX M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
02-11-1921

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

VA.

10b. County

N/A

10c. City, Town or Location

PORTSMOUTH

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1258 WARD TERRACE

10f. Zip Code

23704

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No

If Yes, Give Year or Dates: 1943

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give full work done during most of working life. DO NOT use retired)

DESIGN ENGINEER

16b. Kind of Business/Industry

DESIGN

17. Father's Name (First, Middle, Last)

VERNON THOMAS BOYD

18. Mother's Name (First, Middle, Maiden Surname)

MARY SEARS

19a. Informant's Name/Relationship (Type, Print)

SNELLINGS FUNERAL HOME

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8464 TIDEWATER DRIVE, NORFOLK, VIRGINIA, 23518

20a. Method of Disposition

☐ Burial ☐ Cremation ☒ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

OAK GROVE CEM.

Date

8-5-97

20c. Location - City or Town, State

PORTSMOUTH, VA.

21. Signature of Funeral Service Licensee

R. J. Smith

22. Name and Address of Facility

HENRY W. JENKINS AND SONS COMPANY  
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Ampullary Carcinoma

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hepatic Abscess

Due to (or as a consequence of):

1 week

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HepatitisTOBACCO ABUSE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Gregory M. Maldino MD

29c. License number

RES-000

29d. Date signed (Month, Day, Year)

August 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gregory M. Maldino MD  
600 N. Wolfe Street, Baltimore MD 21287

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia F. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

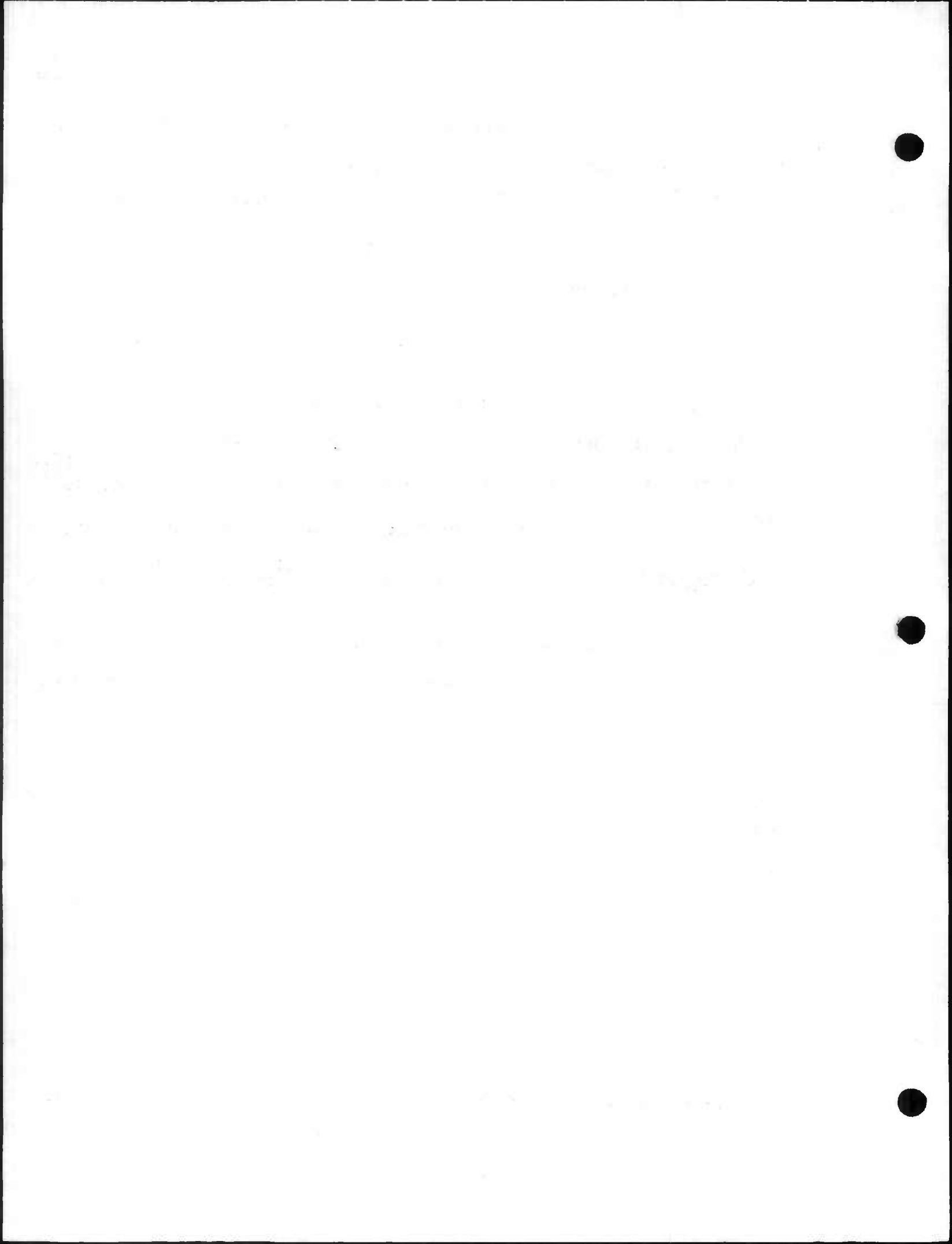
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23557

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARION ESTHER CARNES</b>				2. Date of Death Month Day Year <b>August 4, 1997</b>		3. Time of Death <b>10:15 PM</b>						
	4a. Facility Name (If not institution, give street and number) <b>PRESBYTERIAN HOME OF MARYLAND</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore County</b>						
Funeral Director	5. Social Security Number <b>097-26-2389</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 3, 1909</b>						
	9. Birthplace (State or Foreign Country) <b>New York</b>		10e. State <b>Maryland</b>		10b. County <b>Baltimore County</b>		10c. City, Town or Location <b>Towson</b>						
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number <b>400 Georgia Court</b>		10f. Zip Code <b>21204</b>		10g. Citizen of What Country? <b>USA</b>						
	11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>						
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>5 yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Registered Nurse</b>		16b. Kind of Business/Industry <b>Medical</b>								
	17. Father's Name (First, Middle, Last) <b>John Carnes</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Fannie White</b>								
	19a. Informant's Name/Relationship (Type, Print) <b>Mr. Robert Carnes (Nephew)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>901 Buffalo Street, Olean, NY 14760-2247</b>								
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		Date <b>8/6/97</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>						
	21. Signature of Funeral Service Licensee <i>Martin D. Lawson</i> <b>Martin D. Lawson</b>				22. Name and Address of Facility <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road, Baltimore, Maryland 21212</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>e. <b>PNEUMONIA</b> Due to (or as a consequence of):</td> </tr> <tr> <td>b. <b>RESTRICTIVE LUNG DISEASE</b> Due to (or as a consequence of):</td> </tr> <tr> <td>c. <b>OSTEOPOROSIS</b> Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>PNEUMONIA</b> Due to (or as a consequence of):	b. <b>RESTRICTIVE LUNG DISEASE</b> Due to (or as a consequence of):	c. <b>OSTEOPOROSIS</b> Due to (or as a consequence of):	d.
	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	e. <b>PNEUMONIA</b> Due to (or as a consequence of):											
b. <b>RESTRICTIVE LUNG DISEASE</b> Due to (or as a consequence of):													
c. <b>OSTEOPOROSIS</b> Due to (or as a consequence of):													
d.													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown													
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.													
29b. Signature and title of certifier <i>Barbara J. Carroll, M.D.</i> <b>Barbara J. Carroll, M.D.</b>				29c. License number <b>D38392</b>		29d. Date signed (Month, Day, Year) <b>8/5/97</b>							
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Barbara J. Carroll, M.D., 13801 York Road, Cockeysville, Maryland 21030</b>													
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <i>John Davidson-Randall</i>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23558

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Kenneth C. Cogger</b>				2. Date of Death Month <b>August</b> Day <b>2</b> Year <b>1997</b>		3. Time of Death <b>16:23</b>	
	4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>216-36-7969</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>57</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 20, 1939</b>	9. Birthplace (State or Foreign Country) <b>Ohio</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
	10e. Street and Number <b>1530 N. Fulton Avenue</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>N/A</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>		16b. Kind of Business/Industry <b>Market</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Eric Cogger</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Cook</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Margaret Cogger - mother</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1530 N. Fulton Avenue, Baltimore, MD 21207</b>			
	20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		Date <b>August 8, 1997</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>Carlton C. Douglas</b>		22. Name and Address of Facility <b>Douglass Funeral Service 1701 McCulloch St. Baltimore, MD 21217</b>					
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death
	Immediate Cause (Final disease or condition resulting in death) <b>Sepsis</b>							<b>1 day</b>
	Due to (or as a consequence of): <b>immunosuppression</b>							<b>1 month</b>
	Due to (or as a consequence of): <b>severe COPD</b>							<b>5 years</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>adenocarcinoma of the lung, alcohol abuse, chronic pancreatitis</b>								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. Manner of Death <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Fred Hsieh MD</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 2 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Fred Hsieh, MD Johns Hopkins Hospital Baltimore, MD</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>John Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene

97 23559

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Alexander Campbell Cushing</b>				2. Date of Death Month Day Year <b>Aug. 4, 1997</b>		3. Time of Death <b>8:31 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Keswick Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>219-18-5677</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>75</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 26, 1921</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>700 W. 40th</b>				10f. Zip Code <b>21211</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (14 or 5+)</b> <b>S+</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Attorney</b>			16b. Kind of Business/Industry <b>Law</b>	
17. Father's Name (First, Middle, Last) <b>Edward Brandon Cushing, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Lillian Osborn</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Jane C. Lange/ Sister</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1213 John St., Baltimore, MD 21217</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Lorraine Park Ceme.</b>		Date <b>8-7-97</b>		20c. Location - City or Town, State <b>Woodlawn, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Henry W. Jenkins &amp; Sons</b> <b>4905 York Rd., Baltimore, MD 21212</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Parkinson's Disease</b> Due to (or as a consequence of):  b. <b>Bronchopneumonia</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d. Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>3 years</b> <b>1 week</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 						
29c. License number <b>D12487</b>		29d. Date signed (Month, Day, Year) <b>8-4-97</b>						
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>E. Hunter Wilson, MD</b> <b>6701 N. Charles St., Towson, MD 21204</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

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State of Maryland / Department of Health and Mental Hygiene 97 23560

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ella Booher Cucchiella

2. Date of Death

Month Day Year  
August 4, 1997

3. Time of Death

7:35 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

577-16-2239

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 23, 1909

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

317 Leeanne Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Printing

16b. Kind of Business/Industry

Martin's

17. Father's Name (First, Middle, Last)

Alson Edgerton

18. Mother's Name (First, Middle, Maiden Surname)

Ella Grantham

19a. Informant's Name/Relationship (Type, Print)

Pat Cucchiella /husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

317 Leeanne Road Baltimore MD. 21221

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory Inc. 8/7/97

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex  
300 Mace Ave. Baltimore Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

2 Weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

{

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Tuberculosis

Acute Chronic Respiratory Acidosis

Right Thoracoplasty

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Serena Klugh M.D.

29c. License number

RD2340

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Serena Klugh M.D. 9000 Franklin Square Drive Baltimore, MD 21237

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

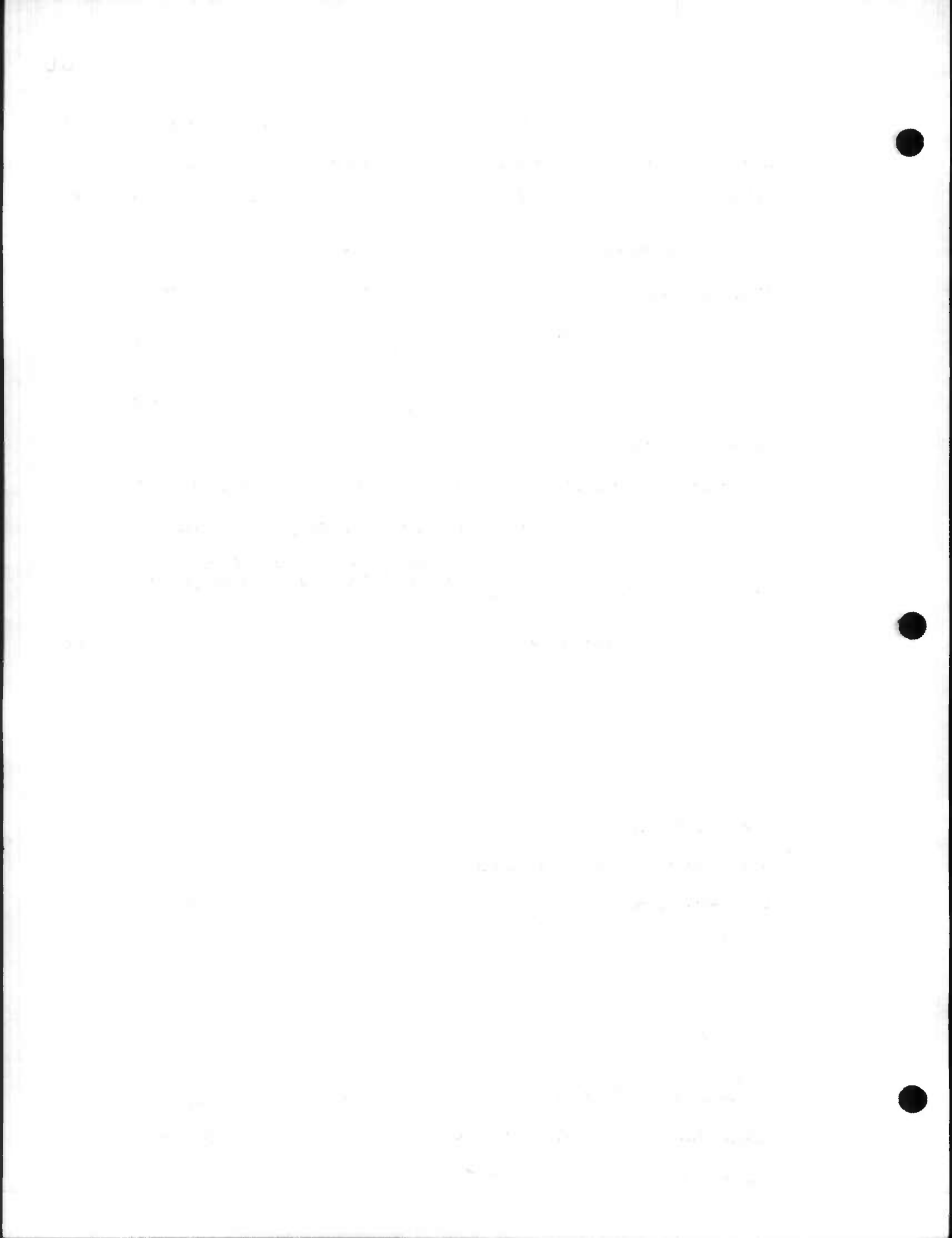
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, it should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

97 23561

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BENJAMIN CORMAN, JR.

2. Date of Death

Month

Day

Year

August

1

1997

3. Time of Death

3:40 PM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-34-5435

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

04/14/1939

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1656 E. 25th STREET

10f. Zip Code

21213

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Home Improvement

17. Father's Name (First, Middle, Last)

Benjamin Corman, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Isabelle Nobles

19a. Informant's Name/Relationship (Type, Print)

Mary Corman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5933 Chinquapin Parkway, Balto., MD 21239

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Cemetery

Date

8/6

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Leroy O. Dyett

22. Name and Address of Facility

LEROY O. DYETT & SON FUNERAL HOME, P.A.  
4600 LIBERTY HEIGHTS AVE., BALTO. 21207

23a. First, enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

10 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Pneumonia

Due to (or as a consequence of):

12 days

c. Chronic Lymphocytic Leukemia

Due to (or as a consequence of):

12 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

History of Alcohol Abuse

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

28. Place of Death (Check only one)

Hospital:

☒ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michelle Aprado, MD

29c. License number

AU4176435A9155

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michelle L. Aprado Union Memorial Hospital Baltimore, MD

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Harrison-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23562

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Harold R. Dove

2. Date of Death

Month Day Year  
July 30 1997

3. Time of Death

4:55 P.M.

4a. Facility Name (If not institution, give street and number)

5700 Park Drive

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

217 34 1747

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 3, 1937

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5700 Park Drive

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

2 College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

FireFighter

16b. Kind of Business/Industry

D.C. Government

17. Father's Name (First, Middle, Last)

Harold I. Dove

18. Mother's Name (First, Middle, Maiden Surname)

Mary B. Herbert

19a. Informant's Name/Relationship (Type, Print)

Jean M. Dove Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5700 Park Drive Bowie Maryland 20715

20a. Method of Disposition

☐ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☒ Other (Specify) Entombment20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Mausoleum

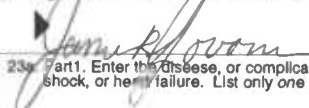
Date

August 4, 1997

20c. Location - City or Town, State

Clinton Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Md. 2071523a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Globulopathy  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Deathone yearSequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb.   
Due to (or as a consequence of):c.   
Due to (or as a consequence of):d.   
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D34423

29d. Date signed (Month, Day, Year)

7/31/97

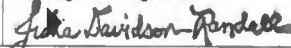
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Andrew Dobin 3231 Sparks Lane A-C Bowie MD 20715

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23563

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM DAVIS</b>				2. Date of Death Month Day Year <b>AUGUST 03 97</b>		3. Time of Death <b>9:05 am</b>	
	4a. Facility Name (If not institution, give street and number) <b>GOOD SAMARITAN HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>239-12-6539</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>78</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01/18/1919</b>	
	9. Birthplace (State or Foreign Country) <b>N. Carolina</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>WOODLAWN</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3104 JEFFREY ROAD</b>		10f. Zip Code <b>21244</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Assembly Line</b>		16b. Kind of Business/Industry <b>General Motors</b>			
	17. Father's Name (First, Middle, Last) <b>Charlie Davis</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Bessie Nunn</b>					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Annie Mae Davis</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3104 Jeffrey Road, Baltimore, MD 21244</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Williams Family Circle Cem.</b>		20c. Location - City or Town, State <b>Apex, North Carolina</b>		20d. Date <b>8/9/97</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>		22. Name and Address of Facility <b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>					
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  e. <b>SEPSIS</b> Due to (or as a consequence of): b. <b>Urinary Tract Infection &amp; Pneumonia</b> Due to (or as a consequence of): c. <b>Chronic Renal Failure</b> Due to (or as a consequence of): d. <b>metastatic Carcinoma of Colon &amp; Prostate</b>		Approximate Interval Between Onset and Death					
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Dua</i> <b>RESIDENT, INT. MED.</b>		29c. License number <b>P 11400</b>		29d. Date signed (Month, Day, Year) <b>8/3/97</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>SAKSHI DUA 5601, LOCH RAVEN BLVD, BALTIMORE, MD</b>							
	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <i>Juha</i>					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23564

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GERALDINE FISHER</b>				2. Date of Death Month <b>AUG</b> Day <b>4</b> Year <b>1997</b>		3. Time of Death <b>4:53PM</b>		
	4e. Facility Name (If not institution, give street and number) <b>339 Bloom Street Apt B.</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>216-42-8981</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>56 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>5-23-41</b>		
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>339 Bloom Street</b>		10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Teachers Aide</b>		16b. Kind of Business/Industry <b>Education</b>		17. Father's Name (First, Middle, Last) <b>Douglas Fisher</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Goins</b>	
19e. Informant's Name/Relationship (Type, Print) <b>Lindell Fisher (Brother)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3511 Oldmill Road Balt MD 21207</b>		20e. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. Location - City or Town, State <b>8/8/97 Baltimore MD</b>	
21. Signature of Funeral Service Licensee <b>Coretha Hector, CFSP</b>		22. Name and Address of Facility <b>E.L. Phillips</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARCINOMA OF BREAST WITH METASTASES</b> Due to (or as a consequence of): <b>ENDOMETRIAL CARCINOMA</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>4 YEARS</b> <b>4 MONTHS</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown		24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>John MacGibbon MD</b>		29c. License number <b>D 06933</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 5 1997</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>JOHN B. MACGIBBON, 101 W READ ST SUITE 119 BALTIMORE MD 21201</b>	
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>Lia Davidson-Randall</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23565

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

Sara Friedman

2. Date of Death

Month  
08

Day  
04

Year  
1997

3. Time of Death

8:13 AM

4a. Facility Name (If not Institution, give street and number)

Cherrywood Manor

4b. City, Town, or Location of Death

Reisterstown

4c. County of Death

Baltimore

5. Social Security Number

375-05-8049

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Feb. 2, 1910

9. Birthplace (State or Foreign Country)

Vermont

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Reisterstown

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12020 Reisterstown Rd.

10f. Zip Code

21136

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Billing Administrator

16b. Kind of Business/Industry

Chrysler Automotive

17. Father's Name (First, Middle, Last)

Jack Press

18. Mother's Name (First, Middle, Maiden Surname)

Bessie Raphael

19a. Informant's Name/Relationship (Type, Print)

Betty Adams

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8808 Center Park Dr. #205, Columbia, MD 21045

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hebrew Memorial Park Cem.

Date

8/6/97

20c. Location - City or Town, State

Mt. Clemens, MI

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.  
6009 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Serious dyspnea*  
Due to (or as a consequence of):

b. *Serious dyspnea*  
Due to (or as a consequence of):

c.   
Due to (or as a consequence of):

d.   
Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

*3 years*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Coronary vascular disease*

*Coronary artery disease*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

D28304

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

750 Main St. Reisterstown MD 21136

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 24 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

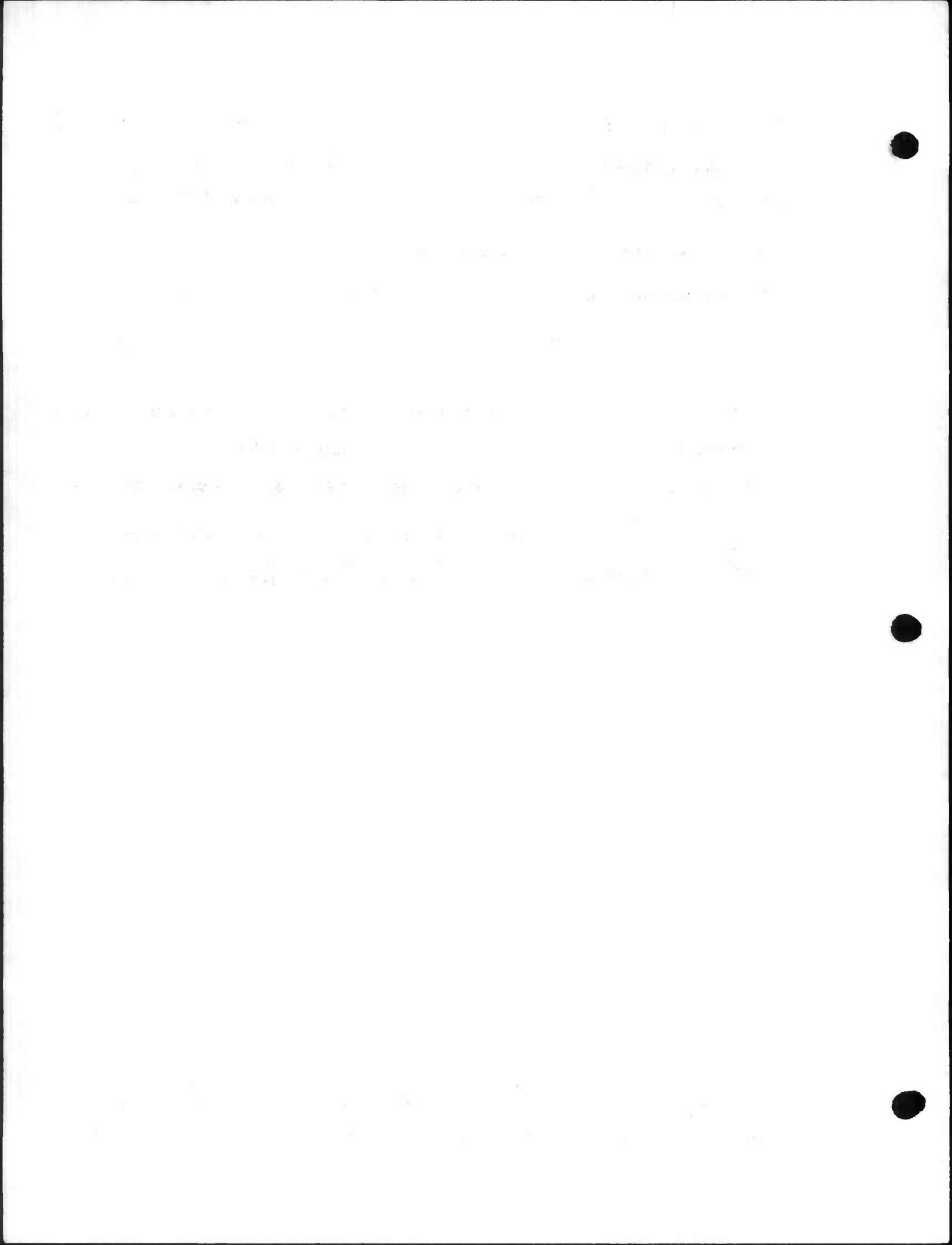
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23566

Item 5 8-11-97 Film G750 W.H.Per F/H

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Helen M. Frith</b>		2. Date of Death Month <b>July</b> Day <b>30</b> Year <b>1997</b>		3. Time of Death <b>1: 30 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>Crofton Convalescent Center</b>		4b. City, Town, or Location of Death <b>Crofton</b>		4c. County of Death <b>Anne Arundel</b>
Funeral Director	5. Social Security Number <b>577-10-1576</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>92</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>March 19, 1905</b>		9. Birthplace (State or Foreign Country) <b>Washington D.C.</b>		
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Bowie</b>
	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>12408 Keynote Lane</b>		10f. Zip Code <b>20715</b>
	10g. Citizen of What Country? <b>United States</b>		11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:
	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
	17. Father's Name (First, Middle, Last) <b>John Portch</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Mary J. Coleman</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Wilfred A. Barber Jr. Grandson</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12414 Keynote Lane Bowie Maryland 20715</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery Aug. 2, 1997</b>		20c. Location - City or Town, State <b>Brentwood Maryland</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Atherosclerotic Heart Disease</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Congestive Heart Failure</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death <b>Yrs.</b>		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b> <b>Congestive Heart Failure</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of injury <b>M</b>	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred			
28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
29b. Signature and title of certifier <b>Rakesh Anand</b>		29c. License number <b>D 20108</b>		29d. Date signed (Month, Day, Year) <b>7/30/97</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>14300 Gallant Fox Lane Bowie Maryland 20715</b>					
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

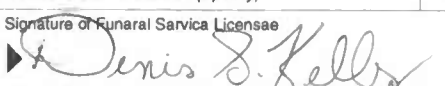
Certificate of Death

Reg. No.

97 23567

Physician  
/Medical  
Examiner

Funeral  
Director


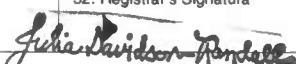
1. Decedent's Name (First, Middle, Last) <b>Francis FRENCH</b>				2. Date of Death Month <b>August</b> Day <b>4</b> Year <b>1997</b>		3. Time of Death <b>12:55 P.M.</b>	
4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
5. Social Security Number <b>216-20-1358</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>70</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>3-4-27</b>	
9. Birthplace (State or Foreign Country) <b>MD</b>							
Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Chase</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>13247 East Greenbank Rd.</b>				10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>2</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Yardmaster</b>		16b. Kind of Business/Industry <b>Port of Baltimore</b>	
17. Father's Name (First, Middle, Last) <b>William E. French</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret Roach</b>			
19a. Informant's Name/Relationship (Type, Print) <b>Mary French/ wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13247 East Greenbank Rd. Chase, MD 21220</b>			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer</b>		Date <b>8-6-97</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Cvach/Rosedale Funeral Home 1211 Chesaco Ave., Rosedale, MD 21237</b>			

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. <b>Respiratory failure</b> Dua to (or as a consequence of):  b. <b>Metastatic melanoma</b> Dua to (or as a consequence of):  c. Dua to (or as a consequence of):  d. Dua to (or as a consequence of):		Approximate Interval Between Onset and Death  <b>2 days</b>  <b>2 years</b>
--	--	---

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of causa of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28f. Location (Street and Number or Rural Route Number, City or Town, State)					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and title of certifier 		29c. License number <b>R D 2125</b>		29d. Date signed (Month, Day, Year) <b>August 4, 1997</b>	
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) <b>Dr. Hamilton Small 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>					
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 			

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23568

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Margaret J. Felson

2. Date of Death

Month Day Year  
August 2 1997

3. Time of Death

12:40pm

4a. Facility Name (If not institution, give street and number)

786 George Road

4b. City, Town, or Location of Death

Essex

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

195-20-5758

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 5, 1923

9. Birthplace (State or Foreign Country)

PA.

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Essex

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

786 George Road

10f. Zip Code

21221

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12th

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

own home

17. Father's Name (First, Middle, Last)

John Stasik

18. Mother's Name (First, Middle, Maiden Surname)

Anna Condo

19a. Informant's Name/Relationship (Type, Print)

Bob Felson /son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1902 Dineen Drive Baltimore Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Holly Hill Cemetery 8/5/97

Date

20c. Location - City or Town, State

Baltimore Md.

21. Signature of Funeral Service Licensee

R. Terry Connelly

22. Name and Address of Facility

Connelly Funeral Home of Essex  
300 Mace Ave. Baltimore Md. 2122123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Myocardial infarction

Due to (or as a consequence of):

b. Art. sclerotic coronary vasc. disease

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Immed.

9 Yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Louis Semenovoff

29c. License number

D 100 32

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Louis SEMENOFF MD / 2108 CREMSTY BAL MD 21220

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23569

Items: 23a part I, 27 per ME0 G-750 8/18/97 <sup>dh</sup> Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Thomas H. Fisher, Jr

2. Date of Death

Month Day Year  
JULY 28, 1997

3. Time of Death

1340 PP

4a. Facility Name (If not institution, give street end number)

1516 BALDWIN ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

213-72-7004

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

40

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep 20, 1956

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street end Number

1333 West 37th Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Construction

16b. Kind of Business/Industry

Otis Insulation

17. Father's Name (First, Middle, Last)

Thomas Fisher, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

June E. Kendall

19a. Informant's Name/Relationship (Type, Print)

Linda Rogers (Sister)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)

5419 Ridge Road, Mt. Airey, Md. 21771

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☒ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Green Mount Crematory

Date

8/4/97

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home  
3818 Roland Avenue, Baltimore, Maryland 2121123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. ACQUIRED IMMUNO DEFICIENCY SYNDROME (AIDS)

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☐ DOA Other: ☐ Nursing Home ☐ Residence ☒ Other (Specify)VACANT  
DWELLING

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street end Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 29, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23570

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Evelyn Lillian Grooms			2. Date of Death Month: August Day: 2 Year: 1997		3. Time of Death 6:35 PM												
	4e. Facility Name (If not institution, give street and number) Genesis Perring Parkway			4b. City, Town, or Location of Death Baltimore		4c. County of Death Baltimore												
Funeral Director	5. Social Security Number 212-30-0232		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) January 23, 1906											
	Usual Residence of Decedent		10a. State Maryland		10b. County Baltimore		10c. City, Town or Location Baltimore											
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 1801 Wentworth Rd.		10f. Zip Code 21034		10g. Citizen of What Country? United States											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White											
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2		16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home													
	17. Father's Name (First, Middle, Last) Daniel Hughes			18. Mother's Name (First, Middle, Maiden Surname) Christine Ender														
	19a. Informant's Name/Relationship (Type, Print) Helen G. Cook/daughter			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1137 E. Northern Pkwy. Baltimore, MD 21239														
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Woodlawn Cemetery		Date 8/7/97		20c. Location - City or Town, State Baltimore, Maryland											
	21. Signature of Funeral Service Licensee John L. Mitchell IV		22. Name and Address of Facility Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, MD 21212															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																	
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a.</td> <td>ventricular dysrhythmia</td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">seconds</td> </tr> <tr> <td>b.</td> <td>coronary artery disease</td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>							Immediate Cause (Final disease or condition resulting in death)	a.	ventricular dysrhythmia	Due to (or as a consequence of):	seconds	b.	coronary artery disease	c.		d.	
	Immediate Cause (Final disease or condition resulting in death)	a.	ventricular dysrhythmia	Due to (or as a consequence of):	seconds													
b.		coronary artery disease																
c.																		
d.																		
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown																		
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																		
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined																		
28a. Date of Injury (Month, Day Year)																		
28b. Time of Injury M																		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																		
28d. Describe how Injury occurred																		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)																		
28f. Location (Street and Number or Rural Route Number, City or Town, State)																		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and Title of certifier Jeffrey Oslen																		
29c. License number D34650																		
29d. Date signed (Month, Day, Year) August 4, 1997																		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 5601 Loch Raven Blvd. Baltimore, MD 21239																		
31. Date filed (Month, Day, Year) AUG 06 1997																		
32. Registrar's Signature John Davidson-Randall																		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

3

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23571

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Physician  
/Medical  
Examiner

Funeral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>ANITA PATRICIA GRAY</b>				2. Date of Death Month Day Year <b>JULY 30, 1997</b>		3. Time of Death <b>2301PM</b>			
4a. Facility Name (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL E.R.</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N. A.</b>			
5. Social Security Number <b>217 92 3567</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>33</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>8-15-63</b>			
9. Birthplace (State or Foreign Country) <b>Md.</b>		10a. State <b>Md.</b>		10b. County <b>N. A.</b>		10c. City, Town or Location <b>Baltimore</b>			
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>2927 N. CALVERT ST</b>		10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>COMPANION AID</b>		16b. Kind of Business/Industry <b>Self</b>					
17. Father's Name (First, Middle, Last) <b>ROBERT J. GRAY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>PATRICIA BAKER</b>					
19a. Informant's Name/Relationship (Type, Print) <b>PATRICIA GRAY (mother)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1908 E. 29th ST. BALTO. MD 21218</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Barron Forest Cn</b>		20c. Location - City or Town, State <b>8/7/97 Owings Mills Md</b>					
21. Signature of Funeral Service Licensee <b>Joseph B. Locke Jr</b>				22. Name and Address of Facility <b>Locke Funeral Home 1304 N. Central St Balto Md 21204</b>					
23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Smoke Inhalation</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
						24a. Was an autopsy performed? <b>Inspection</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No			
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) <b>7-30-97</b>		28b. Time of Injury <b>2217</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
		28d. Describe how injury occurred <b>House Fire</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Apartment</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2935 Calvert Baltimore City, Maryland</b>			
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Allyson N. Mackay MD</b>		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>JULY 31, 1997</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Stephen S. Radeniz 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <b>John Davidson-Randall</b>					

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23572

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard Grimes

2. Date of Death

July 31, 1997

3. Time of Death

3:30 P.M.

4a. Facility Name (If not institution, give street and number)

2641 Kirk Avenue

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

243-16-4558

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JAN 1, 1919

9. Birthplace (State or Foreign Country)

NC

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTO

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2641 KIRK AVE

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1942-194513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

STEEL WORKER

16b. Kind of Business/Industry

STEEL CO

17. Father's Name (First, Middle, Last)

SYLVESTER GRIMES

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE ANDERSON

19a. Informant's Name/Relationship (Type, Print)

BERTHA GRIMESWIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2641 KIRK AVE BALTO, MD 21218

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

GARRISON FOREST VA CEM 1997

Date

AUG 7

20c. Location - City or Town, State

owings mills, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility BETTS FUNERAL HOME

1129 N. CAROLINE ST BALTO, MD 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

e. Metastatic Adenocarcinoma of Pancreas

Approximate  
Interval Between  
Onset and Death

2 months

Due to (or as a consequence of):

Immediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D15450

29d. Date signed (Month, Day, Year)

8/1/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Mohamed Al-Ibrahim, M.D., 10 N. Greene Street, Baltimore, MD 21201

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

20113

01472

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23573

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY J. HERRINGTON

2. Date of Death

Month August Day 2 Year 1997

3. Time of Death

00:00

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL CENTER

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215 05 0939

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 6, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

204 - 10th Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Wire line

16b. Kind of Business/Industry

Westinghouse

17. Father's Name (First, Middle, Last)

Joseph Obzut

18. Mother's Name (First, Middle, Maiden Surname)

Frances

(not Available)

19a. Informant's Name/Relationship (Type, Print)

Kenneth Jordan / son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5409 Park Road Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Glen Haven Memorial Park 8/6/97

Date

20c. Location - City or Town, State

Glen Burnie, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Gonce Funeral Home P.A.  
4001 Ritchie Highway Baltimore, Md. 21225

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

CARDIOPULMONARY ARREST

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

a.

Due to (or as a consequence of):

SEPSIS AND Acute Renal Failure

1 week

b.

Due to (or as a consequence of):

Urinary Tract Infection

1 week

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

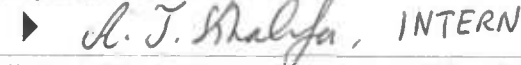
28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

 INTERN

29c. License number

AS 2441614A7

29d. Date signed (Month, Day, Year)

AUGUST, 2, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

AHMAD JAHAL KHALIFA ASALEH, HARBOR HOSPITAL CENTER

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that this certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23574  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Loyal, W

Hartmann

2. Date of Death

Month August

Day 1

Year 1997

3. Time of Death

1552

4a. Facility Name (If not Institution, give street and number)

Johns Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

215-12-0065

6. Sex

152 M 20 F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Feb. 13, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Baltimore

10c. City, Town or Location

Edgemere

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

3125 Lodge Farm Road

10f. Zip Code

21219

10g. Citizen of What Country?

U.S.A.

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

XX

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

XX Yes, Give Year or Dates

WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes XX No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Machine Operator

16b. Kind of Business/Industry

Lever Bros.

17. Father's Name (First, Middle, Last)

Frederick William Hartmann

18. Mother's Name (First, Middle, Maiden Surname)

Rose Deares

19a. Informant's Name/Relationship (Type, Print)

Loyal W. Hartmann, Jr./Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1215 S. Clinton St., Balto., Md. 21224

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

XX

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Holly Hill Cemetery

8/6/97

Data

20c. Location - City or Town, State

Baltimore, Md

21. Signature of Funeral Service Licensee

Charles S. Zeiler &amp; Son

22. Name and Address of Facility

21224  
Charles S. Zeiler & Son 901 S. Conkling St

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Anoxic Brain Injury

18 hours

Due to (or as a consequence of):

b.

Chronic obstructive Pulmonary Disease

10 years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 20 No

Hospital:

10 Inpatient 20 ER/Outpatient 30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home 50 Residence 60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
20 Accident investigation  
30 Suicide 60 Could not be  
40 Homicide determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

medical House staff

29c. License number

N5057

29d. Date signed (Month, Day, Year)

August, 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ian Krop 600 N Wolfe St Baltimore MD 21205

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23575

Item: 8 per F.H.G-750 8/19/97 reb

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Madeleine Choe Hernandez

2. Date of Death

Month August Day 2, Year 1997

3. Time of Death

10:00 A.M.

4a. Facility Name (If not institution, give street and number)

8002 Fox Glen Court

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

058-84-4996

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

3 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

7/23/94

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Germany

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Glen Burnie

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8002 Fox Glen Court

10f. Zip Code

21060

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Puerto Rican

14. Race - American Indian, Black, White, etc.

Specify: Asian American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Gilbert Hernandez

18. Mother's Name (First, Middle, Maiden Surname)

Kum Hyong Choe

19a. Informant's Name/Relationship (Type, Print)

Gilbert Hernandez/Father

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8002 Fox Glen Ct., Glen Burnie, MD 21060

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

8-5-97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

Stephen D. Lohrmann

22. Name and Address of Facility

CAFA-Stephen D. Lohrmann, P.A.

8717 Green Pastures Drive, Baltimore MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ENTEROCOCCAL SEPSIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 WEEK

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. RELAPSED ACUTE MYELOGENOUS LEUKEMIA 3 WEEKS

Due to (or as a consequence of):

c. ACUTE MYELOGENOUS LEUKEMIA

Due to (or as a consequence of):

2.2 YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

PATRICIA SUE DINDORF

29c. License number

D44452

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PATRICIA SUE DINDORF: 111 MICHIGAN AVE, WASHINGTON DC, 20010

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

L. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

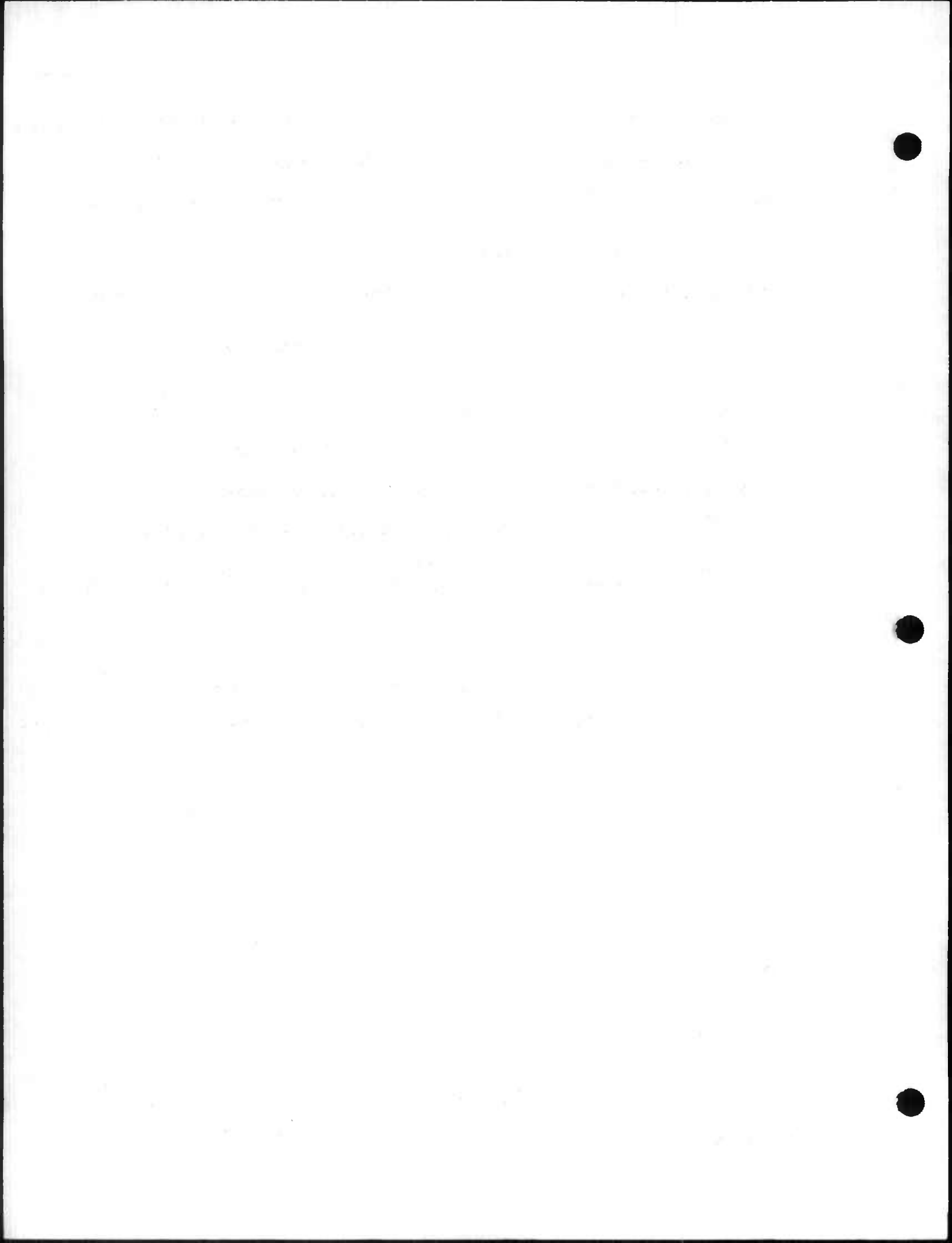
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23576

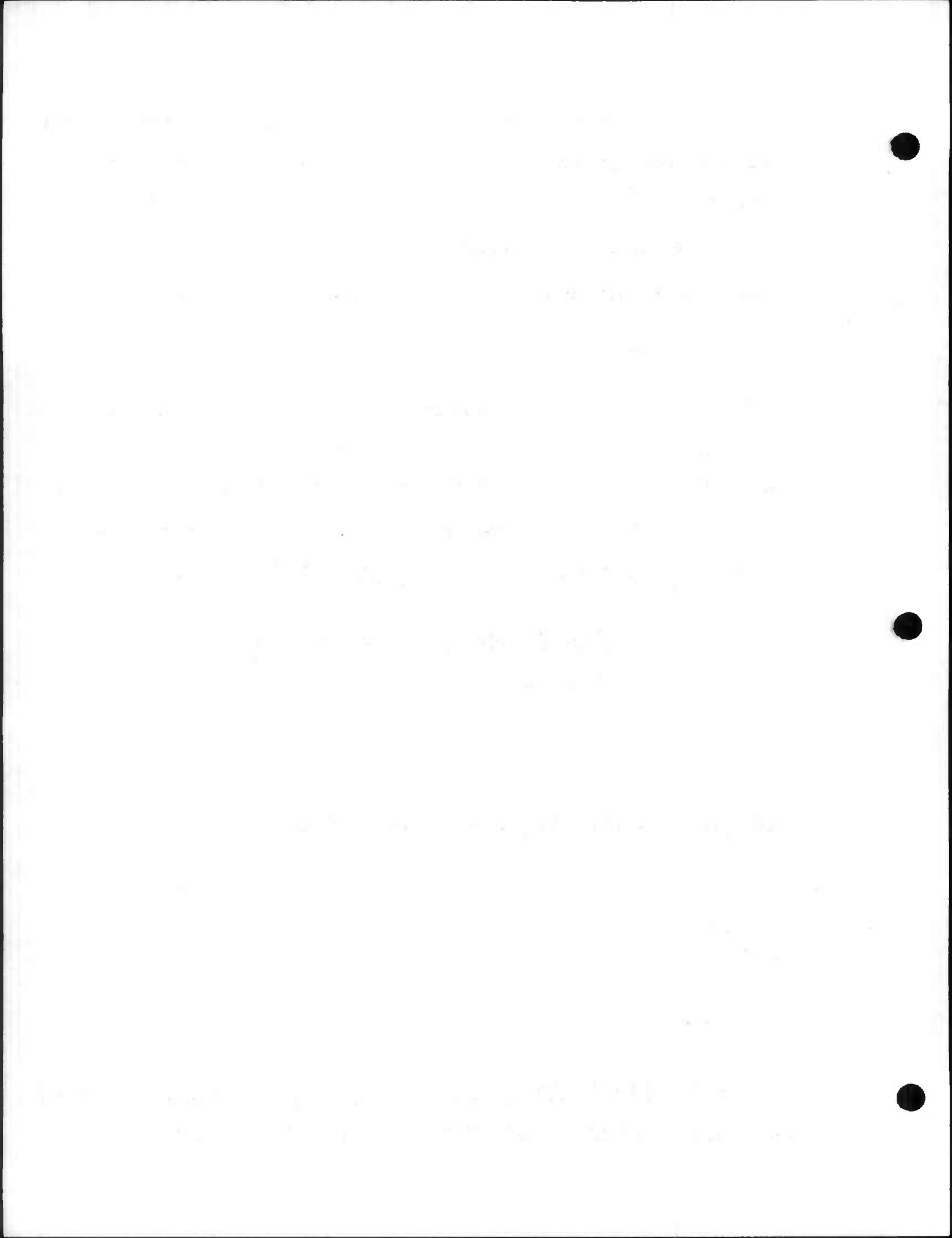
Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ROLAND PAGE HALL</b>				2. Date of Death Month <b>August</b> Day <b>5</b> Year <b>1997</b>		3. Time of Death <b>4:30 AM</b>	
	4e. Facility Name (If not institution, give street and number) <b>8620 Kelso Dr. Apt. A109</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>235-10-6682</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>80</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Jan. 6, 1917</b>	9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent							
10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>8620 Kelso Dr. Apt. A109</b>				10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WW II</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Painter</b>		16b. Kind of Business/Industry <b>American Standard Co.</b>		
17. Father's Name (First, Middle, Last) <b>Harry Hall</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Pagie Myers</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Kathleen Hall</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8620 Kelso Dr. Apt. A109, Baltimore, MD 21221</b>				
20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Monte Vista Park Cem.</b>		Date <b>8/8/97</b>		20c. Location - City or Town, State <b>Bluefield, WV</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214</b>				
23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CONGESTIVE CARDIOMYOPATHY</b> Due to (or as a consequence of): <b>b. ASCVD</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MEDIASTINITIS, Hypertension, COPD</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how Injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>H41069</b>		29d. Date signed (Month, Day, Year) <b>August 5, 1997</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. Stanley Kuman 1308 Business Center Way, Edgewood</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director  
To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23577

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA L. HENNELLY

2. Date of Death

August 5 1997 1:50AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

219-12-6086

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 11 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State  
Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1717 Belt Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Housewife/Domestic

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

Charles N. Clem

18. Mother's Name (First, Middle, Maiden Surname)

Edith E. Claybaugh

19a. Informant's Name/Relationship (Type, Print)

Lorena Duncan (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1717 Belt Street, Baltimore, Md. 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Crownsville V.A. Cemt.

Date

Aug. 8

1997

20c. Location - City or Town, State

Crownsville, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home of South Balto.  
130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE

Due to (or as a consequence of):

c. DEMENTIA

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending2 ☐ Accident

investigation

3 ☐ Suicide6 ☐ Could not be4 ☐ Homicide

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

M

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

1545149

29d. Date signed (Month, Day, Year)

August 5 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANARAP. B

301 HOSPITAL DRIVE

GLEN BURNIE

MD 21061

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transitPhysician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Name: Clara L. Hennelly  
Baltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23578

Item 10bcef Per FH Film G750 8-6-97 rja

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLARA E. HOHMAN

2. Date of Death

August 3 1997

3. Time of Death

1:15 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

817 CAMP MEADE ROAD CHESAPEAKE HOSPICE

4b. City, Town, or Location of Death

Linthicum

4c. County of Death

Anne Arundel Co.

5. Social Security Number

212-16-2972

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept. 6 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

Cecil  
~~Anne Arundel Co.~~

10c. City, Town or Location

Elkton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

503 North Street

~~5600 Moore Street~~

10f. Zip Code

21921

~~21225~~

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Housewife

16b. Kind of Business/Industry

Home Owner

17. Father's Name (First, Middle, Last)

William T. Rhodes

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Ellen Vickers

19a. Informant's Name/Relationship (Type, Print)

Shirley Ferguson (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

731 Deering Road Pasadena, Md. 21122

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Pk.

Date

Aug. 5 1997

20c. Location - City or Town, State

Glen Burnie, Md.

21. Signature of Funeral Service Licensee

Edward Lewis

22. Name and Address of Facility

McCully-Polyniak Funeral Home of Pasadena  
3204 Mountain Road, Pasadena, Md. 21122

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRO VASCULAR ACCIDENT

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ONB

WERN

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

CHESAPEAKE HOSPICE

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Edward Lewis MD

29c. License number

D21776

29d. Date signed (Month, Day, Year)

AUGUST 4 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SUNYA MONDRA MD 202 B PATAPSCO AVE BALTIMORE 21221

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 23579

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Carrie Howard</b>		2. DATE OF DEATH MONTH DAY YEAR <b>August 2 1997</b>		3. TIME OF DEATH HOUR MIN. SEC. <b>1:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-60-1647</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.	
7. DATE OF BIRTH MONTH DAY YEAR <b>May 2, 1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>Tennessee</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Church Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>n/a</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7232 German Hill Road</b>		10f. ZIP CODE <b>21222</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Unknown</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Wyengar</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Tina Hatteras</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Samuel Howard/son</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9128 Philadelphia Road Baltimore Md.</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holly Hill Cemetery 8/6/97</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>R. Terry Connelly</b>		22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Cholecystitis</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death <b>days</b> <b>days</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY HOUR MIN. SEC. 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rudolf T. H. ... M.D.</b>		29c. LICENSE NUMBER <b>D40525</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/21/97</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rudolf T. H. ... M.D. Church Hospital</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 06 1997</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been approved by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

ITEM: 4 per DR. G-750 8-  
Item 10e, 20b per FH Film G750 8-6-97 rja

Certificate of Death

97 23580

Reg. No.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

1. Decedent's Name (First, Middle, Last) <b>MICHAEL SCOTT JACKSON Jr.</b>		2. Date of Death Month <b>August</b> Day <b>2</b> Year <b>1997</b>		3. Time of Death <b>12:40 PM</b>	
4a. Facility Name (If not institution, give street and number) <b>Johns Hopkins Hospital</b>		4b. City, Town, or Location of Death <b>Baltimore City</b>		4c. County of Death <b>n/a</b>	
5. Social Security Number <b>219-37-9901</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>4</b> Yrs.	
8. Date of Birth (Month, Day, Year) <b>NOV. 13, 92</b>		9. Birthplace (State or Foreign Country) <b>MARYLAND</b>			
Usual Residence of Decedent					
10a. State <b>MD</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>BALTIMORE</b>	
10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No					
10e. Street and Number <b>2111 TUCKER LANE apt A8</b>		10f. Zip Code <b>21207</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:	
14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>na</b> College (1-4 or 5+) <b>-</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>CHILD</b>		16b. Kind of Business/Industry <b>n/a</b>	
17. Father's Name (First, Middle, Last) <b>MICHAEL SCOTT JACKSON SR.</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>FATIMA CHEATHAM</b>			
19a. Informant's Name/Relationship (Type, Print) <b>FATIMA CHEATHAM- MOTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2111 TUCKER LANE, BALTIMORE, MD 21207 apt 8</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		20c. Location - City or Town, State <b>8-5-97 BALTIMORE, MD</b>	
21. Signature of Funeral Service Licensee <b>Gabrielle Curk</b>		22. Name and Address of Facility <b>WM.C. MARCHE H.-4300 WABASH AVENUE</b>			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
Immediate Cause (Final disease or condition resulting in death)		a. <b>Brainstem glioma</b>		Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		b.		Due to (or as a consequence of):	
		c.		Due to (or as a consequence of):	
		d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.					
29b. Signature and title of certifier <b>Neurology Resident</b>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 2, 1997</b>	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Isaac Silverman - Pathology 509, 600 N. Wolfe St - Baltimore, MD 21287</b>					
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>Kristina [Signature]</b>			

State Registrar



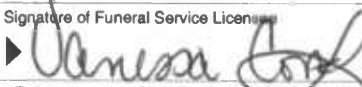

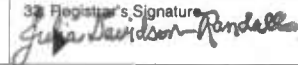
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23581

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Jacqueline Joyner</b>				2. Date of Death Month <b>08</b> Day <b>03</b> Year <b>97</b>		3. Time of Death <b>2:03</b>		
	4a. Facility Name (If not institution, give street and number) <b>University of Maryland Medical System</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>		
Funeral Director	5. Social Security Number <b>217-80-6897</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>35</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>01-30-62</b>		
	9. Birthplace (State or Foreign Country) <b>Washington</b>		10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>4744 Wrenwood Avenue</b>		10f. Zip Code <b>21212</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th Grade</b> College (1-4 or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cashier</b>		16b. Kind of Business/Industry <b>Facilities</b>		17. Father's Name (First, Middle, Last) <b>Clarence E. Joyner</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Magnolia Hillard</b>	
19a. Informant's Name/Relationship (Type, Print) <b>Clarence Joyner</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4744 Wrenwood Avenue Baltimore, Maryland 21212</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Voshell Mem. Gardens</b>		20c. Date <b>08-07-97</b>	
20d. Location - City or Town, State <b>Dundalk, Md.</b>		21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  a. <b>Acute aortic regurgitation</b> Due to (or as a consequence of): b. <b>Endocarditis (bacterial)</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.		Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>	
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>P097.53</b>		29d. Date signed (Month, Day, Year) <b>8/3/97</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Hamary M. Patel 22 South Greene St Baltimore Md. 21201-1595</b>		31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23582

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JAMES JOHNSON</b>				2. Date of Death Month <b>JULY</b> Day <b>21</b> Year <b>1997</b>		3. Time of Death <b>1550</b>	
	4a. Facility Name (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>262-22-4549</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>84</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>OCT. 23, 1912</b>	
	9. Birthplace (State or Foreign Country) <b>MD</b>							
Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>GLEN BURNIE</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
10e. Street and Number <b>7343 FURNANCE BRANCH RD</b>				10f. Zip Code <b>21060</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>N/A</b>			16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>UNKNOWN</b>			16b. Kind of Business/Industry <b>N/A</b>		
17. Father's Name (First, Middle, Last) <b>JAMES A JOHNSON</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MARY JOHNSON</b>				
19a. Informant's Name/Relationship (Type, Print) <b>SHIRLEY ALSTON/FRIEND</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7347 FURNANCE BRANCH RD, GLEN BURNIE, MD 21060</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>MT. ZION CEM</b>			20c. Location - City or Town, State <b>AUG 1 1997 BALTO, MD</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>BETTS FUNERAL HOME 1129 N. CAROLINE ST BALTO, MD 21213</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death
Immediate Cause (Final disease or condition resulting in death)								
a. <b>renal tubular acidosis</b>								<b>1 week</b>
Due to (or as a consequence of):								
b. <b>metastatic pancreatic cancer</b>								<b>6 months</b>
Due to (or as a consequence of):								
c.								
Due to (or as a consequence of):								
d.								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						
		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 			29c. License number <b>RES-0000</b>			29d. Date signed (Month, Day, Year) <b>JULY 21, 1997</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DORIS SEVER, 240 BOX, 15 CHARLES PLAZA #1203 SOUTH, BALTIMORE, MD 21201</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>			32. Registrar's Signature 					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23583

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George

2. Date of Death

August

Day 4, Year 1997

3. Time of Death

4:22 AM

4a. Facility Name (If not institution, give street and number)

Maryland General Hospital

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

216-05-0219

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80

8. Date of Birth

6-07-1917

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1400 E. Madison St. Apt. 710

10f. Zip Code

21205

10g. Citizen of What Country?

USA

11. Marital Status

☐ Navar Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12 th

College (1-4 or 5+)

18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Barber

16b. Kind of Business/Industry

State of Md.

17. Father's Name (First, Middle, Last)

Moses Jones

18. Mother's Name (First, Middle, Maiden Surname)

Mary Jones

19a. Informant's Name/Relationship (Type, Print)

Jerome Jones (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8841 Terrell Rd. Perry Hall Md. 21236

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus Memorial

Date

8-7-97

20c. Location - City or Town, State

Arbutus, Maryland

21. Signature of Funeral Service Licensee

Dennis B. Caple

22. Name and Address of Facility

Caple Funeral Service  
5502 Winner Ave. Balto., Md. 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. respiratory failure

Due to (or as a consequence of):

b. pneumonia

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital: ☒ Inpatient ☐ ER/Outpatient ☐ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicidal ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? ☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Ashraf Mostafa, M.D.

29c. License number

89266

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ashraf Mostafa, M.D. 60 Maryland General Hospital.

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.



# MISSING

DEATH

certificate no.: 97-23583

DEATH

DL-93283

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23584

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marie Jonas

2. Date of Death

Month Day Year  
August 2 1997

3. Time of Death

9:25 AM

4a. Facility Name (If not institution, give street and number)

FRANKLIN WOODS NURSING

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213103277

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 2, 1918

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

ROSEDALE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8117 ANALEE AVENUE

10f. Zip Code

21237

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

18b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

ANTHONY NORKUS

18. Mother's Name (First, Middle, Maiden Surname)

ANTOINETTE BAGDONAS

19a. Informant's Name/Relationship (Type, Print)

MARY A. JONAS / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8117 ANALEE AVE ROSEDALE, MD 21237

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARDENS OF FAITH

Date

8/5/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

CVACH/ROSEDALE FUNERAL HOME  
1211 CHESACO AVE 21237

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. malnutrition

Due to (or as a consequence of):

b. Alzheimer's disease

Due to (or as a consequence of):

c. a Right Lower Lobe Pneumonia

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Nabrawski MD

29c. License number

D37612

29d. Date signed (Month, Day, Year)

8/2/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1201 AGORA Drive 2C - Bel AIR MD 21014

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Rendall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23585

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn Elizabeth Kowalski

2. Date of Death

Month Day Year  
August 2, 1997

3. Time of Death

5:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

217-14-1461

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 13, 1920

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Perry Hall

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4252 Chapel Road

10f. Zip Code

21128

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas Francis McNicholas

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Ashcom Caulk

19a. Informant's Name/Relationship (Type, Print)

Edmund W. Kowalski (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4252 Chapel Rd., Perry Hall, MD 21128

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens of Faith Cem.

Date

8/7/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 2123623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. atherosclerotic cardiovascular disease 1d

Due to (or as a consequence of):

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic obstructive pulmonary disease  
severe atherosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D44804

29d. Date signed (Month, Day, Year)

8/5/97

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

KARIN M. DODGE MD 4920 Campbell Blvd White Marsh MD 21236

31. Date filed (Month, Day, Year)

AUG 06 1997

Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23586

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Florence L. Kaminski</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>2:20 A.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>7636 Beach Drive</b>				4b. City, Town, or Location of Death <b>Pasadena</b>		4c. County of Death <b>Anne Arundel</b>		
Funeral Director	5. Social Security Number <b>213 03 9449</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>78</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>May 15, 1919</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>7636 Beach Drive</b>				10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.</b>		
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Solderer</b>				16b. Kind of Business/Industry <b>Westinghouse</b>		
	17. Father's Name (First, Middle, Last) <b>Charles Dashner</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florence Collins</b>				
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Bernard Kaminski Sr. /husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7636 Beach Drive Pasadena, Maryland 21122</b>				
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>		Date <b>8/5/97</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
	21. Signature of Funeral Service Licensee <i>Jerome J. [Signature]</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>Lung Carcinoma with metastasis months</b> Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Right Breast Carcinoma</b> Due to (or as a consequence of):								
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown 24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Right Breast Carcinoma</b>									
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
29b. Signature and title of certifier <i>Salvacion A. Dupaya</i>				29c. License number <b>D38912</b>		29d. Date signed (Month, Day, Year) <b>08-01-97</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SALVACION A Dupaya 1720 Cran Highway Route 204 Glen Burnie MD 21061</b>									
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <i>Davidson-Randall</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The law requires that the death certificate be executed within 24 hours after death.

To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23587  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AGNES G. KELLY</b>				2. Date of Death Month <b>AUG.</b> Day <b>3</b> Year <b>1997</b>		3. Time of Death <b>9:45 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>LORIEN FRANKFORD NURSING HOME</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>220-62-4380</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>90</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>12/28/06</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE CITY</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number <b>1543 BURNWOOD ROAD</b>		10f. Zip Code <b>21239</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNAVAILABLE</b> College (1-4 or 5+) <b>UNAVAILABLE</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PAYROLL CLERK</b>		16b. Kind of Business/Industry <b>UNAVAILABLE</b>			
	17. Father's Name (First, Middle, Last) <b>UNAVAILABLE</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>UNAVAILABLE</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>ARTHUR DRAGER ATTORNEY</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5 LIGHT STREET BALTIMORE, MD 21202</b>					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		Date <b>8/7/97</b>		20c. Location - City or Town, State <b>BALTIMORE, MD</b>	
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Colon Cancer</b>						Approximate Interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aortic Stenosis</b> <b>Aneurysm</b>							
	23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Colon Cancer</b>							
Physician /Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)	
	28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
	28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D34145</b>	
	29d. Date signed (Month, Day, Year) <b>8/7/97</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Gitter, MD 21 CROSS ROADS DRIVE OWINGS MILLS, MD 21117</b>		31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 	
	33. Registrar's Signature 							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

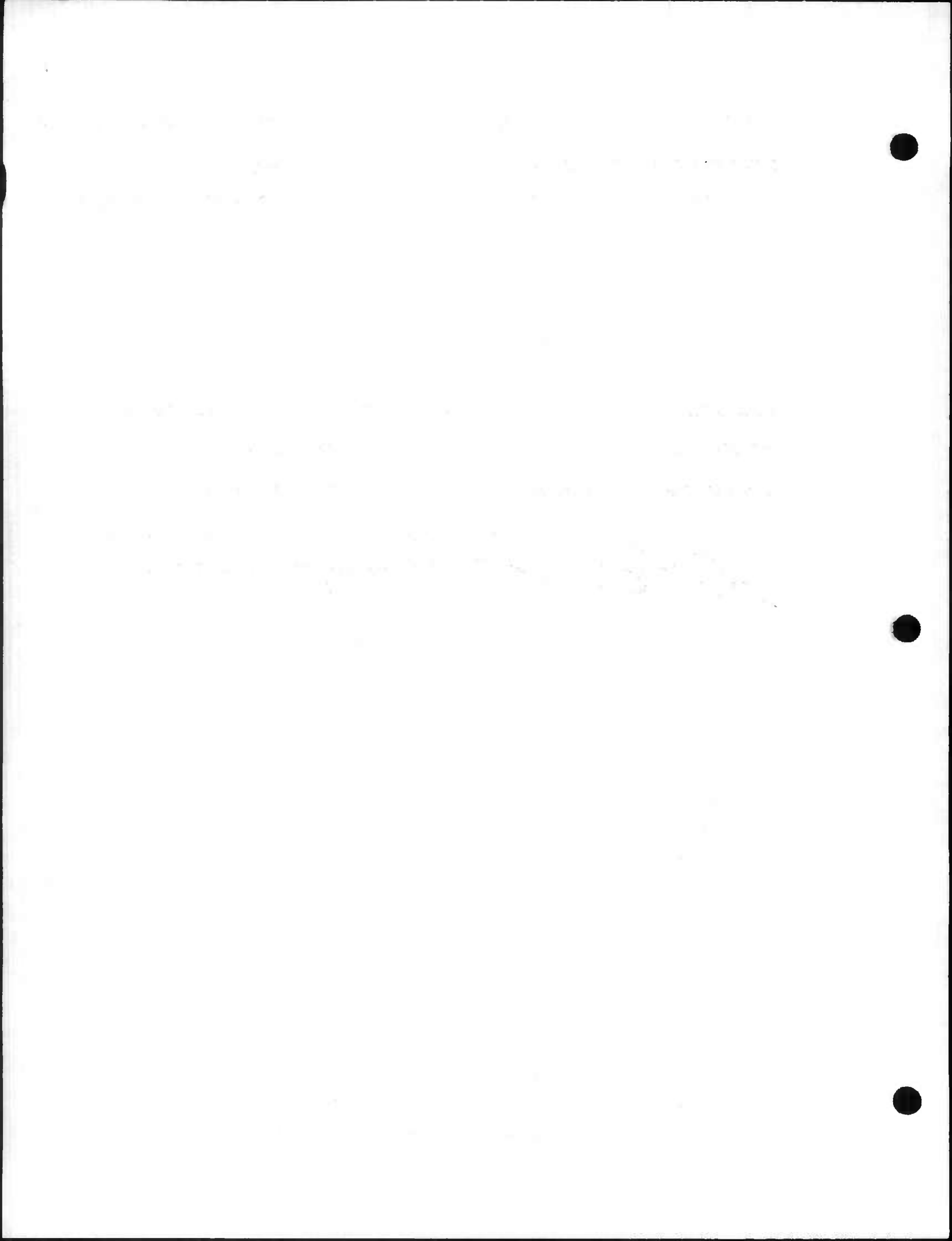
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23588

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALEX A. KOSKI

2. Date of Death

Month  
August

Day

01, 1997

3. Time of Death

03:50PM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

219-03-2368

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11/4/18

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8127 LOCH RAVEN BLVD.

10f. Zip Code

21286

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ELECTRICIAN

16b. Kind of Business/Industry

DEPT. STORE

17. Father's Name (First, Middle, Last)

ALEX KOSTKOSKI

18. Mother's Name (First, Middle, Maiden Surname)

HELEN LASKOWSKI

19a. Informant's Name/Relationship (Type, Print)

LINDA STEVENS

DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1460 ROCK RIDGE ROAD JARRETTSVILLE, MD 21084

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

8/6/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.

TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

one hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 16608

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

KAM KEN LEUNG, M.D., Perry Point, Maryland 21902

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Name known to physician: ALEX A. KOSKI

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23589**  
**Certificate of Death**

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charlotte C. Lingenfelter</b>				2. Date of Death Month <b>August</b> Day <b>4</b> Year <b>1997</b>		3. Time of Death <b>5:05 AM</b>											
	4a. Facility Name (If not Institution, give street and number) <b>Manor Care Rossville Nursing Home</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Baltimore</b>											
Funeral Director	5. Social Security Number <b>171-07-5498</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>82</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Dec. 15, 1914</b>	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>										
	Usual Residence of Decedent																	
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No										
	10e. Street and Number <b>12 Ratna Court</b>				10f. Zip Code <b>21236</b>		10g. Citizen of What Country? <b>U.S.A.</b>											
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Welder</b>			16b. Kind of Business/Industry <b>Manufacturing</b>										
	17. Father's Name (First, Middle, Last) <b>Charles Albert Young</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Marie Meda McDonald</b>													
	19a. Informant's Name/Relationship (Type, Print) <b>Linda M. Getz (daughter)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12 Ratna Court, Baltimore, MD 21236</b>													
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem.</b>		20c. Location - City or Town, State <b>8/8/97 Owings Mills, Maryland</b>											
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>													
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death									
	<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td rowspan="4">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last</td> <td>e. <b>End Stage COPD</b> Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>b. <b>Severe coronary artery disease</b> Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>c. <b>malnutrition</b> Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table>									Immediate Cause (Final disease or condition resulting in death)	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. <b>End Stage COPD</b> Due to (or as a consequence of):		b. <b>Severe coronary artery disease</b> Due to (or as a consequence of):		c. <b>malnutrition</b> Due to (or as a consequence of):		d.
Immediate Cause (Final disease or condition resulting in death)	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	e. <b>End Stage COPD</b> Due to (or as a consequence of):																
		b. <b>Severe coronary artery disease</b> Due to (or as a consequence of):																
		c. <b>malnutrition</b> Due to (or as a consequence of):																
		d.																
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown												
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No												
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No										
				28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)											
				28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																		
29b. Signature and title of certifier MD				29c. License number <b>037612</b>			29d. Date signed (Month, Day, Year) <b>8/5/97</b>											
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>ALABRASH, MD 1201 AGORA Drive, 2C, BelAIR MD 21014</b>																		
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>																		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar  
DHMM 16 Rev 6/95



97 23590

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CONSTANCE LINHART</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>3</b> YEAR <b>97</b>		3. TIME OF DEATH <b>9 35 AM</b>	
4. SOCIAL SECURITY NUMBER <b>212-16-2331</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 19, 1907</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Genesis Eldercare-Perring Parkway</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Jarrettsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4042 Hunt Crest Road</b>				10f. ZIP CODE <b>21084</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Tax Preparer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Stanislaus Lubinski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sophie (Surname Unknown)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Daniel Miller (nephew)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4042 Hunt Crest Road, Jarrettsville, MD 21084</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 8/6</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Schimunek Funeral Homes, Inc. 9705 Belair Rd., Baltimore, MD 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of Pancreas</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death: <b>1 year</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Osteoarthritis</b> <b>Cardiovascular disease</b> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> N		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D08358</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/4/97</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SPACILIA PATRICKO</b> <b>8903 HARTFORD ROAD</b> <b>BALTIMORE MARYLAND 21234</b>				31. DATE FILED (Month, Day, Year) <b>AUG 06 1997</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

TO THE REGISTRAR: This certificate should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPRINTED: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23591

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Hazel M. Lilly</b>				2. Date of Death Month: <b>August</b> Day: <b>1</b> Year: <b>1997</b>		3. Time of Death <b>8:00 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>1839 S. Charles Street</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>365 34 1066</b>		6. Sex <b>1</b> M <b>2</b> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months: Days:	If Under 24 Hrs. Hours: Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 11, 1934</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>			10d. Inside City Limits <b>1</b> Yes <b>2</b> No	
10e. Street and Number <b>1821 Light Street</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>U.S.</b>		
11. Marital Status <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <b>1</b> Yes <b>2</b> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> Yes <b>2</b> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>Own Home</b>		
17. Father's Name (First, Middle, Last) <b>Homer McCray</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mablene Davis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Leroy R. Lilly Jr. / husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1821 Light Street Baltimore, Maryland 21230</b>				
20a. Method of Disposition <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		Date <b>8/5/97</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>		
21. Signature of Funeral Service Licensee <i>Richard E. Davis</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>e. Dilated Cardio Myopathy</b> Due to (or as a consequence of): <b>b. Renal failure</b> Due to (or as a consequence of): <b>c. Chronic obstructive pulmonary disease</b> Due to (or as a consequence of): <b>d. Hypertension Anterior Sclerotic Cardiovascular</b>  Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>5 yrs</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. <b>Diabetes mellitus</b>								23b. Did tobacco use contribute to the cause of death? <b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown
24a. Was an autopsy performed? <b>1</b> Yes <b>2</b> No								24b. Were autopsy findings available prior to completion of cause of death? <b>1</b> Yes <b>2</b> No
25. Was case referred to medical examiner? <b>1</b> Yes <b>2</b> No		26. Place of Death (Check only one) Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)						
27. Manner of Death <b>1</b> Natural <b>5</b> Pending investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>4</b> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury et Work? <b>1</b> Yes <b>2</b> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Christopher de Borja M.D.</i>		29c. License number <b>042820</b>		29d. Date signed (Month, Day, Year) <b>08/04/97</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Christopher de Borja 3708 Mountain Rd. Pasadena Md. 21222</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <i>John A. Henderson</i>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23592

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RAYMOND E. LANE

2. Date of Death

Month  
AUGUSTDay  
1Year  
1997

3. Time of Death

14:40 PM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL 900 S CATON AVE

4b. City, Town, or Location of Death

BALTIMORE, MD 21229

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

226-28-8513

6. Sex

102 M 20 F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

Month, Day, Year

JAN 31, 1924

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

703 MT. HOLLY ST.

10f. Zip Code

21229

10g. Citizen of What Country?

U.S.A

11. Marital Status

10 Navar Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

10 Yes 20 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

GTA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FOREMAN

16b. Kind of Business/Industry

CONSTRUCTION

17. Father's Name (First, Middle, Last)

EDDIE LAYNE

18. Mother's Name (First, Middle, Maiden Surname)

MAGGIE WALTON

19a. Informant's Name/Relationship (Type, Print)

JEANETTE LANE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 MT. HOLLY ST. BALTIMORE, MD 21229

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 75 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Cemetery

Date

8/2/97

20c. Location - City or Town, State

BALTIMORE MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Registry

GARY P. MARSH FUNERAL HOME PA  
270 FREDALTON PASS BALTIMORE, MD 21229

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Ventricular fibrillation

Due to (or as a consequence of):

minutes.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. atherosclerotic cardiovascular disease

Due to (or as a consequence of):

years.

c. diabetes mellitus

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure on dialysis.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy performed?

10 Yes 20 NO

24b. Were autopsy findings available prior to completion of cause of death?

10 Yes 20 NO

25. Was case referred to medical examiner?

10 Yes 20 NO

Hospital:

10 Inpatient

20 Outpatient

30 DOA

26. Place of Death (Check only one)

Other: 40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending Investigation  
20 Accident 60 Could not be determined  
30 Suicide 40 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

10 Yes 20 No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

B-37659

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

900 caton avenue, Baltimore, Maryland 21229

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23593

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Jane SHOREX Leist.</i>				2. Date of Death Month <i>August</i> Day <i>4</i> Year <i>1997</i>		3. Time of Death <i>355 AM</i>		
	4a. Facility Name (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>220-14-0535</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>70</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>0818-1926</b>		
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>620 WEST UNIV. PARKWAY</b>		10f. Zip Code <b>21210</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> Collage (1-4 or 5+) <input checked="" type="checkbox"/> 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>HOUSEWIFE/VOLUNTEER</b>		16b. Kind of Business/Industry <b>HOMEMAKER</b>					
17. Father's Name (First, Middle, Last) <b>EDWARD GETTIER SHIPLEY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>EDNA FEAGANS</b>					
19a. Informant's Name/Relationship (Type, Print) <b>FREDERICK LEIST JR. (HUSB.)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>620 WEST UNIV. PARKWAY BALTO., MD. 21210.</b>					
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY</b>		20c. Date <b>8/5/97</b>		20d. Location - City or Town, State <b>BALTO., MD.</b>			
21. Signature of Funeral Service Licensee <i>William R. Jenkins</i>				22. Name and Address of Facility <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212.</b>					
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Uro sepsis</b> Due to (or as a consequence of): <b>b. Hydronephrosis</b> Due to (or as a consequence of): <b>c. metastatic colon cancer</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>One day</b> <b>one month.</b> <b>unknown.</b>	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>gastrointestinal bleeding</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. Place of Death (Check only one) Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <i>Bartholomew</i>		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 4<sup>th</sup> 1997.</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Bartholomew Johns Hopkins Bayview.</b>									
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <i>Julia [Signature]</i>					

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23594

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LILLIAN LAMBIE

2. Date of Death

Month Day Year  
AUGUST 3, 1997

3. Time of Death

5:00 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

BERLIN NURSING &amp; REHABILITATION CENTER

4b. City, Town, or Location of Death

BERLIN, MD.

4c. County of Death

WORCESTER CO.

5. Social Security Number

219 16 6690

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JUNE 21 1902

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

WORCESTER

10c. City, Town or Location

BERLIN, MD.

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5 MYSTIC HARBOUR BLVD.

10f. Zip Code

21811

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

HOME

17. Father's Name (First, Middle, Last)

FRANK WIRTZ

18. Mother's Name (First, Middle, Maiden Surname)

PAULINE ( UNKNOWN )

19a. Informant's Name/Relationship (Type, Print)

MRS. SARA DIXON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13031 BOTTOM RD. HYDES, MD. 21082

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

PARKWOOD CEMETERY

Date

8/6/97

20c. Location - City or Town, State

BALTIMORE, MD.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

HARTLEY MILLER FUNERAL HOME

7527 HARFORD RD. BALTIMORE, MD. 21234

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Cerebral Vascular Accident 3d day.

Due to (or as a consequence of):

b. Cerebral Arteriosclerosis yes.

Due to (or as a consequence of):

c. Diabetes mellitus-insulin dep 7 yr.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD (Chronic Obstructive Pulmonary Disease)  
Degenerative Joint Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DA2502133

29d. Date signed (Month, Day, Year)

Aug 4-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederico A. Torres MD, P.O. Box 799 Berlin MD, 21811

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the physician has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

5

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item:19a per F.H.G-750 8/8/97

State of Maryland / Department of Health and Mental Hygiene

97 23595

Item 19b per FH Film G750 8-6-97 rja

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>ERNEST LEE MOODY</b>				2. Date of Death Month <b>AUGUST</b> Day <b>3</b> Year <b>1997</b>		3. Time of Death <b>9pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>GENESIS ELDER CARE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>215-14-0894</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>74</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6-8-1923</b>	
	9. Birthplace (State or Foreign Country) <b>BALTIMORE, MD</b>		10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>RANDALLSTOWN</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>3913 AMY LANE</b>		10f. Zip Code <b>2113</b>		10g. Citizen of What Country? <b>UNITED STATES</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>master's</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>TEACHER</b>		16b. Kind of Business/Industry <b>BALTIMORE SCHOOL SYSTEM</b>			
	17. Father's Name (First, Middle, Last) <b>FRANK MOODY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ADA BROWN</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>GEORGIANNA MOODY-WIFE</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3913 AMY LANE, BALTIMORE CO, MD 21113</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial Park</b>		20c. Location - City or Town, State <b>8-8-97 Randallstown, Md</b>			
	21. Signature of Funeral Service Licensee <b>Babriele Clark</b>				22. Name and Address of Facility <b>WM. C. MARCH FH.-4300 WABASH AVENUE</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. PNEUMONIA</b> Due to (or as a consequence of):							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No								
Physician /Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
	29b. Signature and title of certifier <b>Sheila Cabben, M.D.</b>				29c. License number <b>D38708</b>		29d. Date signed (Month, Day, Year) <b>8/4/97</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>SHEILA CABBEN, 4000 OLD COURT ROAD, SUITE 203, BALTIMORE, MD 21208</b>							
	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <b>Julia Davidson-Randall</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State Registrar



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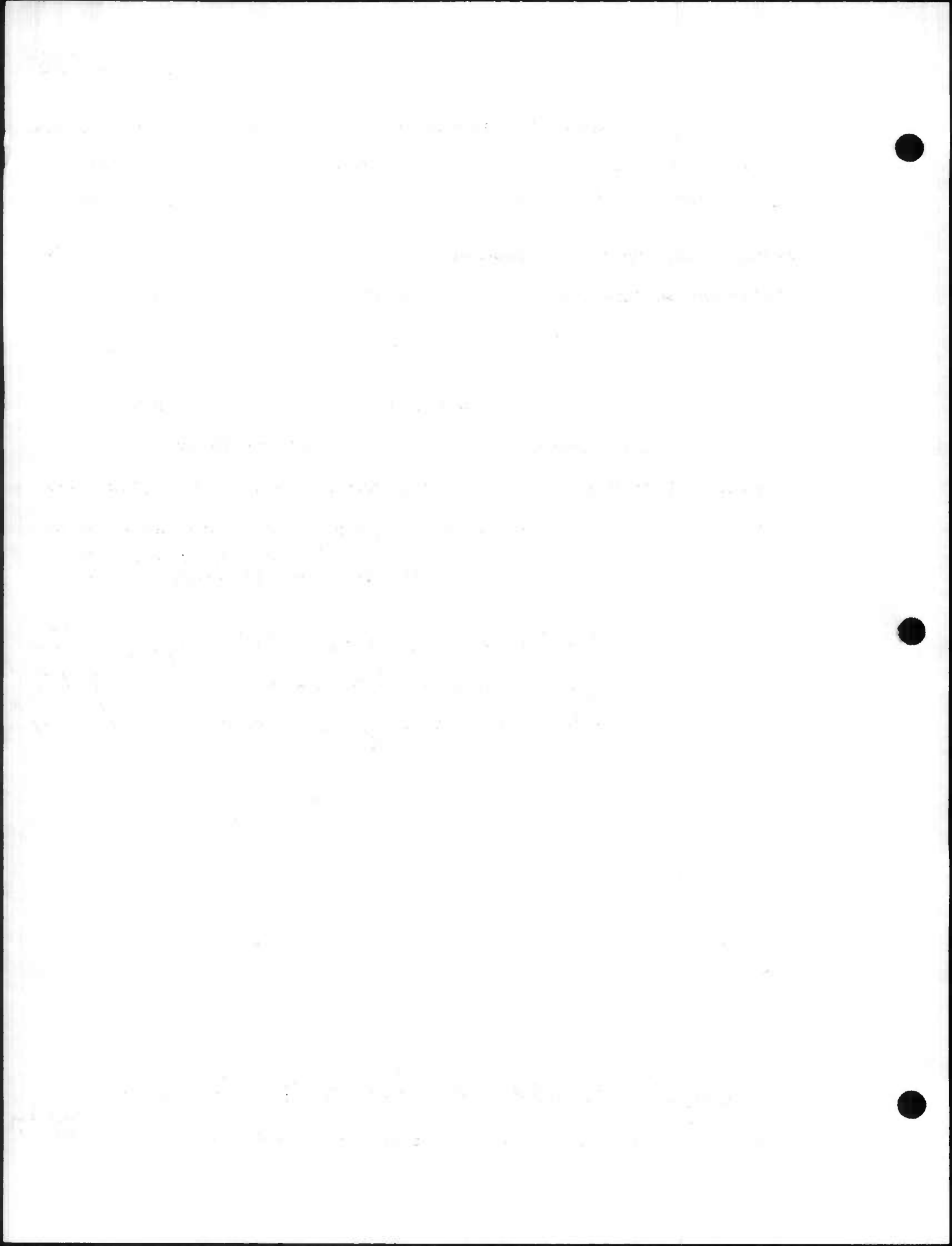
State of Maryland / Department of Health and Mental Hygiene

97 23596

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Bernadette Elizabeth Mullins</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>1:40 A.M.</b>	
	4e. Facility Name (If not institution, give street and number) <b>287 Stanley Terrace</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>215 01 0429</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 12, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>7640 Water Oak Point Road</b>				10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (14 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Maker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>John Schalitzy</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Frances Stillings</b>			
	19e. Informant's Name/Relationship (Type, Print) <b>Bernadette Colhouer / niece</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>287 Stanley Terrace Baltimore, Maryland 21225</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		Data <b>8/4/97</b>		20c. Location - City or Town, State <b>Glen Burnie, Maryland</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div style="width: 35%;"> <p>a. <b>probable cardiac arrhythmia</b> Due to (or as a consequence of):</p> <p>b. <b>respiratory failure</b> Due to (or as a consequence of):</p> <p>c. <b>terminal lung cancer</b> Due to (or as a consequence of):</p> <p>d.</p> </div> </div>							
	23b. Did tobacco use contribute to the cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No							
	26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)							
State Registrar	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <i>[Signature]</i> <b>Jerry D. Skarbek, M.D.</b>				29c. License number <b>029767</b>		29d. Date signed (Month, Day, Year) <b>08-01-97</b>	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Jerry D. Skarbek, M.D. 8418 Baltimore-Annapolis Blvd MD 21122</b>							
	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <i>[Signature]</i>			





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State of Maryland / Department of Health and Mental Hygiene

97 23597

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Evelyn Grace Marshall</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>6 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Denton University of Maryland Medicine</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>n/a</b>	
Funeral Director	5. Social Security Number <b>220-24-9746</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>92</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>July 4 1905</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>n/a</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10e. Street and Number <b>129 E. Randall Street</b>				10f. Zip Code <b>21230</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>0</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Home Owner</b>	
	17. Father's Name (First, Middle, Last) <b>Walter E. White</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Mary C. Mitchell</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Wayne Marshall (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>157 Leppo Road Westminster, Md. 21158</b>			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Baltimore Cemetery</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>		20d. Date <b>Aug. 5 1997</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Daniel A. Taylor</b>				22. Name and Address of Facility <b>McCully-Polyniak Funeral Home of South Balto. 130 E. Fort Ave., Baltimore, Md. 21230</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Sepsis / Pneumonia</b> Due to (or as a consequence of): <b>Cerebro Vascular accident</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension</b> Due to (or as a consequence of): <b>long standing many years</b>				Approximate Interval Between Onset and Death <b>6 weeks</b> <b>1989</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Serious Decubities, Congestive heart failure</b>				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings evaluable prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
To Be Completed by Physician/Medical Examiner	28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>James P. G. Flynn MD</b>		29c. License number <b>001346</b>		29d. Date signed (Month, Day, Year) <b>Aug 2 1997</b>	
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JAMES FLYNN Denton Special Hospital / Home 611 S. Charles 21230</b>				31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>			
	32. Registrar's Signature <b>Davidson</b>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item 28c 9-29-97 Film G751 W.H. Per Doctor State of Maryland / Department of Health and Mental Hygiene 97 23598  
Item 27, 28abcdef Per FH Film G751 Per PHY 9-25-97

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ronald Louis Maher</b>				2. Date of Death Month <b>7</b> Day <b>31</b> Year <b>97</b>		3. Time of Death <b>02:18</b>	
	4a. Facility Name (If not institution, give street and number) <b>R.A. Cowley Shock Trauma Center</b>				4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>213-32-3189</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>06-28-1925</b>	9. Birthplace (State or Foreign Country) <b>DC</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Monkton</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
	10e. Street and Number <b>16323 Old York Rd.</b>				10f. Zip Code <b>21111</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Attorney</b>		16b. Kind of Business/Industry <b>Law</b>	
	17. Father's Name (First, Middle, Last) <b>Thomas Francis Maher</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Florence O'Donnell</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Anne S. Maher/ Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16323 Old York Rd., Monkton, MD 21111</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		Date <b>8-1-97</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>	
	21. Signature of Funeral Service Licensee <b>James R. Keh</b>				22. Name and Address of Facility <b>Henry W. Jenkins &amp; Sons Co. 4905 York Rd., Baltimore, MD 21212</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Tracheal Aspiration</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>c.</b> Due to (or as a consequence of): <b>d.</b> Due to (or as a consequence of):							Approximate Interval Between Onset and Death <b>1 day</b> <b>1 day</b>
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>C1/2 Quadriplegia since 11/28/96</b> <b>Pseudomonas Urinary Tract Infection</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>Nov. 28, 1996</b>		28b. Time of Injury <b>Noon</b> M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>Fell Off Horse</b>
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>Polo Field</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Manor Rd. Monkton</b>		29b. Signature and title of certifier <b>H. Neal Reynolds MD</b>		29c. License number <b>D27163</b>
29d. Date signed (Month, Day, Year) <b>7/31/97</b>		30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>H. Neal Reynolds, R.A. Cowley Shock Trauma, 22 S. Greene St. Balto.</b>						
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>James R. Keh</b>						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23599

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Benjamin F. Mister

2. Date of Death

Month  
August

Day

3

Year

1997

3. Time of Death

12:15 AM

4a. Facility Name (If not institution, give street and number)

Union Memorial Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-36-7961

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

Nov. 4, 1938

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3603 Keystone Avenue

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

10

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Carpenter

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Daniel Mister

18. Mother's Name (First, Middle, Maiden Surname)

Lillian Sommers

19a. Informant's Name/Relationship (Type, Print)

Phyllis Mister (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3603 Keystone Avenue, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Dulaney Valley Mem Garden 8/6/97 Timonium, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

A. Alan Seitz, Jr.

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home  
3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute Exacerbation of Chronic Obstructive Pulmonary Disease

28 days

Due to (or as a consequence of):

b. Chronic Obstructive Pulmonary Disease / Emphysema

20 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Ischemic Cardiomyopathy

Chronic Renal Failure

Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

A. Alan Seitz, Jr. MD PhD

29c. License number

AT 2438946

29d. Date signed (Month, Day, Year)

August 3, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARK D. PHILLIPS MD PhD 3702 MONTEREY RD BALTIMORE MD 21218

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filed by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23600

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Evelyn G. Mechalske

2. Date of Death  
Month Day Year  
Aug. 5, 19973. Time of Death  
6:30am

4a. Facility Name (If not institution, give street and number)

3605 Ash Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-03-4691

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Feb 28, 1921

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3605 Ash Street

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

unk

18. Mother's Name (First, Middle, Maiden Surname)

Mable James

19a. Informant's Name/Relationship (Type, Print)

Ernest Mechalske (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3605 Ash Street, Baltimore, Maryland 21211

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Lorraine Park Cemetery

Date

8/8/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

A. Alan Seitz, Jr. Funeral Home

3818 Roland Avenue, Baltimore, Maryland 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Pulmonary Hypertension  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and DeathSequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

033220

29d. Date signed (Month, Day, Year)

8/5/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

37 Betsy A. Fay, M.D. 3730 Falls Rd. Balto. Md 21211

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
9059.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This death certificate must be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23601

Item 10e 8-11-97 Film G750 W.H.Per F/H

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WILLIAM MAGEE</b>		2. Date of Death Month <b>August</b> Day <b>3</b> Year <b>1997</b>		3. Time of Death <b>12:05 AM</b>
	4a. Facility Name (If not institution, give street and number) <b>NORTHWEST HOSPITAL CENTER</b>		4b. City, Town, or Location of Death <b>RANDALLSTOWN</b>		4c. County of Death <b>BALTIMORE</b>
Funeral Director	5. Social Security Number <b>245-20-7442</b>	6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>01/11/1925</b>		9. Birthplace (State or Foreign Country) <b>N. Carolina</b>		
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>N/A</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2510 PARK HEIGHTS TERRACE</b>		10f. Zip Code <b>21215</b>		10g. Citizen of What Country? <b>U.S.A.</b>
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> Collage (1-4 or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Laborer</b>		16b. Kind of Business/Industry <b>Construction</b>		
	17. Father's Name (First, Middle, Last) <b>Willie Magee</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>Hazel Prince</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>Thelma Hill</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2510 Park Heights Terrace, Balto., MD 21215</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem.</b>		20c. Location - City or Town, State <b>Owings Mills, MD</b>
	21. Signature of Funeral Service Licensee <b>Leroy O. Dyett</b>		22. Name and Address of Facility <b>LERROY O. DYETT &amp; SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>		
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Failure</b>				Approximate Interval Between Onset and Death <b>2 weeks</b>
	23b. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Renal Failure</b>				
	23c. Part III. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Renal Failure</b>				
	23d. Part IV. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Acute Renal Failure</b>				
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Renal Failure</b>				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		
	28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
	29b. Signature and title of certifier <b>[Signature] MD</b>		29c. License number <b>248700</b>		29d. Date signed (Month, Day, Year) <b>August 3, 1997</b>
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A.T. IMPERIAL, JR - Northwest Hosp. Center</b>					
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>[Signature]</b>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



NATHANIEL  
MCFADDEN

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State of Maryland / Department of Health and Mental Hygiene

97 23602

Items: 23a part I, II, 27, 28a-f per MEO G-750 8/22/97 dh Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>NATHANIEL EDWARD MCFADDEN</b>				2. Date of Death Month <b>AUGUST</b> Day <b>03</b> Year <b>1997</b>		3. Time of Death <b>02:20 AM</b>		
	4e. Facility Name (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>		
Funeral Director	5. Social Security Number <b>214-62-7175</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>42</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>09/18/1954</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent								
10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
10e. Street and Number <b>2506 MCHENRY STREET</b>				10f. Zip Code <b>21223</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (14 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Home Care Provider</b>			16b. Kind of Business/Industry <b>State of Maryland</b>		
17. Father's Name (First, Middle, Last) <b>Eugene McFadden</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Ellen Rush</b>					
19e. Informant's Name/Relationship (Type, Print) <b>Eugene McFadden</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2506 McHenry Street, Balto., MD 21223</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		Date <b>8/6</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>					
23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. COCAINE INTOXICATION</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b>								Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BLUNT FORCE INJURIES</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8/3/97</b>		28b. Time of Injury <b>1:30</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred <b>used drugs and involved in altercation</b>	
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>300 block Maryland St., Baltimore City, Maryland</b>					
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Medical Examiner		1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier 				29c. License number <b>OCME</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 03, 1997</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>AM Dixon 111 Penn Street, Baltimore, Maryland 21201</b>									
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 23603

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>MARY HELEN NEUTZE</b>				2. Date of Death Month <b>JULY</b> Day <b>30</b> Year <b>1997</b>		3. Time of Death <b>08:55 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>212 20 8524</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>71</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 24, 1925</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>							
To Be Completed by Funeral Director	Usual Residence of Decedent							
	10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	10e. Street and Number <b>3 Winding Woods Way</b>				10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>School Aide</b>		16b. Kind of Business/Industry <b>Elementary Schools</b>			
	17. Father's Name (First, Middle, Last) <b>Joseph Prematta</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Annie Zcarcie</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>David Neutze / son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Winding Woods Way Pasadena, Maryland 21122</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		Date <b>8/4/97</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediata Cause (Final disease or condition resulting in death) <b>a. CORONARY ARTERY DISEASE</b> Due to (or as a consequence of):  <b>b.</b> Due to (or as a consequence of):  <b>c.</b> Due to (or as a consequence of):  <b>d.</b> Due to (or as a consequence of):  Sequitally list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>JULY 30, 1997</b>		
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>DR. EMIL HAYER MD 600 NORTH WOLFE STREET, BALTIMORE, MARYLAND</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



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LINDA

State of Maryland / Department of Health and Mental Hygiene

97 23604

NEWTON Items: 23a part 1, 27, 28a-f per MEO G-750 8/18/97 Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>LINDA M NEWTON</b>		2. Date of Death Month <b>AUGUST</b> Day <b>2</b> Year <b>1997</b>		3. Time of Death <b>5:10 P.M.</b>
	4a. Facility Name (If not institution, give street and number) <b>2806 W. MULBERRY STREET</b>		4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>na</b>
Funeral Director	5. Social Security Number <b>216-78-0072</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>38</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.
	8. Date of Birth (Month, Day, Year) <b>JUN. 9, 1959</b>				
To Be Completed by Funeral Director	Usual Residence of Decedent				
	10a. State <b>MD</b>	10b. County <b>n/a</b>	10c. City, Town or Location <b>BALTIMORE</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>4614 PEN LUCY ROAD apt.B</b>		10f. Zip Code <b>21229</b>		10g. Citizen of What Country? <b>UNITED STATES</b>
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:
	15. Decedent's Education (Specify only highest grade completed) <b>12 th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>		16b. Kind of Business/Industry <b>DISABLED</b>
	17. Father's Name (First, Middle, Last) <b>JOHN E. FIELDS</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>ADA DAILEY</b>		
	19a. Informant's Name/Relationship (Type, Print) <b>ADA FIELDS- MOTHER</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4614 PEN LUCY ROAD, BALTIMORE, MD #29</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>BALTIMORE NATIONAL</b>		20c. Location - City or Town, State <b>8-8-97 BALTIMORE, MD</b>
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility <b>WM. C. MARCH FH.-4300 WABASH AVENUE</b>		
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) <b>a. NARCOTIC AND ALCOHOL INTOXICATION</b> Due to (or as a consequence of):				
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b>				
	<b>c. Due to (or as a consequence of):</b>				
	<b>d. Due to (or as a consequence of):</b>				
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown				
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) <b>8/2/97</b>		
	28b. Time of Injury <b>P found: 5:00</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>found: private dwelling</b>		28d. Describe how injury occurred <b>unknown</b>			
28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2806 W. Mulberry Street, Baltimore, Maryland</b>					
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. Signature and Title of Certifier 		29c. License number <b>O.C.M.E.</b>		29d. Date signed (Month, Day, Year) <b>AUGUST 3, 1997</b>	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>					
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

97 23605

Item 24a 8-6-97 Film G750 W.H. Per Doctor

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Arnold Nelson

2. Date of Death

Month

Day

Year

07

29

97

3. Time of Death

0946

4a. Facility Name (If not institution, give street and number)

Coulley Shock Trauma Center

4b. City, Town, or Location of Death

Baltimore, MD

4c. County of Death

Baltimore, MD

Funeral  
Director

5. Social Security Number

233-06-2310

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

33

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 23, 1964

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

WV

10b. County

Pocahontas

10c. City, Town or Location

Barstow

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

PO Box 192

10f. Zip Code

24920

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

12

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Timber Cutter

16b. Kind of Business/Industry

Lumber Co.

17. Father's Name (First, Middle, Last)

James Howard Nelson, II

18. Mother's Name (First, Middle, Maiden Surname)

Evelyn Louise Carr

19a. Informant's Name/Relationship (Type, Print)

Priscilla A. Nelson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

PO Box 192, Barstow, WV 24920

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbovale Cemetery

Date

8/2/97

20c. Location - City or Town, State

Arbovale, WV

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Traumatic Brain Injury

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Tree falling on patient

Due to (or as a consequence of):

[Signature]  
CERTIFICATION APPROVED BY MEDICAL EXAMINER

c. Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

29 July 97

28b. Time of Injury

1500 M

28c. Injury at Work?

1 ☒ Yes 2 ☐ No

28d. Describe how injury occurred

Occurred while logging

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

While logging/Gimes Logs

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Cumber/md, md

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Roy Myers MD

29c. License number

D23286

29d. Date signed (Month, Day, Year)

July 30th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STC UMD Med System 225 GREENE ST. BALTIMORE MD 21201

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed with the Maryland Department of Health and Mental Hygiene within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23606

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Jeanette L. Near				2. Date of Death Month August Day 1 Year 1997		3. Time of Death 9:30 PM	
	4a. Facility Name (If not Institution, give street and number) Prince George's Hospital				4b. City, Town, or Location of Death Cheverly		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 362 36 7519		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) June 12 1906	
	9. Birthplace (State or Foreign Country) Michigan		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Bowie	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 12102 Linden Lane		10f. Zip Code 20715		10g. Citizen of What Country? United States	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No) If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Collegia (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker		16b. Kind of Business/Industry Own Home			
	17. Father's Name (First, Middle, Last) Peter McVannel		18. Mother's Name (First, Middle, Maiden Surname) Genevieve (Unavailable)		19a. Informant's Name/Relationship (Type, Print) Marjory L. Near Daughter		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12102 Linden Lane Bowie Maryland 20715	
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Washington National Cemetery		20c. Location - City or Town, State Suitland Maryland			
	21. Signature of Funeral Service Licensee Michael J. Byrne		22. Name and Address of Facility Robert E. Evans Funeral Home Inc. 16000 Annapolis Rd. Bowie Md. 20715		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Respiratory Failure Due to (or as a consequence of): Aspiration Due to (or as a consequence of): Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Septicemia, Anemia Due to (or as a consequence of):		Approximate Interval Between Onset and Death > 2 months	
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown		24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier S. J. Rao		29c. License number D-34525		29d. Date signed (Month, Day, Year) 08-02-97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S. J. Rao, MD - 4000 Mitchellville Road, #220, Bowie MD 20716		31. Date filed (Month, Day, Year) AUG 06 1997		32. Registrar's Signature Julia Anderson-Randall			

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This form requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23607

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HANS PETER ODIN

2. Date of Death

Month Day Year  
August 1, 1997

3. Time of Death

9:45 AM

4a. Facility Name (If not institution, give street and number)

4303 Conowingo Rd.

4b. City, Town, or Location of Death

Darlington

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

212-10-2855

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb. 21, 1915

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7801 Beverly Ave.

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Administrator

16b. Kind of Business/Industry

Defense contractor

17. Father's Name (First, Middle, Last)

Ans Peter Odin

18. Mother's Name (First, Middle, Maiden Surname)

Estrid Lund

19a. Informant's Name/Relationship (Type, Print)

Jeffrey E. Odin

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1603 E. Branch Ct., Forest Hill, MD 21050

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory

Date

8/4/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ALTENBURG FUNERAL HOME, P.A.

6009 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. Progressive Renal Failure  
Due to (or as a consequence of):b. Nephrosclerosis  
Due to (or as a consequence of):c. Nephrotic Syndrome  
Due to (or as a consequence of):

d.

within  
one month

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dilated Cardiomyopathy  
Diabetes Mellitus Type II

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Assisted living

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

NOT applicable

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANUEL M. VAZANTIN MD

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours of death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23608

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>AUDREY JOSEPHINE PICARELLO</b>				2. Date of Death Month <b>August</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>4:11 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>Bel Air Nursing &amp; Rehabilitation Center</b>				4b. City, Town, or Location of Death <b>Bel Air</b>		4c. County of Death <b>Harford</b>			
Funeral Director	5. Social Security Number <b>215-48-5877</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Nov. 21, 1917</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Harford</b>		10c. City, Town or Location <b>Bel Air</b>			10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
	10e. Street and Number <b>731 Danville Circle</b>				10f. Zip Code <b>21014</b>		10g. Citizen of What Country? <b>U.S.A.</b>			
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3rd grade</b> College (1-4or 5+) <b></b>				16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own home</b>			
	17. Father's Name (First, Middle, Last) <b>Benjamin F. Appold</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Edna D. LaMolte</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Robert Picarello (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>731 Danville Circle, Bel Air, MD. 21014</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cem.</b>		Date <b>8/4/97</b>		20c. Location - City or Town, State <b>Baltimore, Maryland</b>			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Schimunek Funeral Home of Bel Air, Inc. 610 W. MacPhail Road, Bel Air, MD. 21014</b>					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Congestive heart failure years</b> Due to (or as a consequence of): <b>b. Severe, bilateral carotid artery occlusion years</b> Due to (or as a consequence of): <b>c. Asymmetric Septal Hypertrophy one year</b> Due to (or as a consequence of): <b>d. Reflux Esophagitis</b>									
	23f. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dehydrated state, hypernatremia, senile dementia. Non-insulin dependent diabetes</b>									
Physician /Medical Examiner	23g. Approximate Interval Between Onset and Death				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown					
	24e. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)							
Medical Certification: To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
	29b. Signature and title of certifier 				29c. License number <b>D 18779</b>		29d. Date signed (Month, Day, Year) <b>August 2, 1997</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Albert S. C. Sun, M.D. 1800 Harford Road, Fallston MD 21047</b>									
State Registrar	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature 					





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23609

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LONNIE ROBERT PERRY SR.

2. Date of Death

Month Day Year  
AUGUST 2, 1997

3. Time of Death

1:24 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

220-12-9344

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 5, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

907 E. Lake Avenue

10f. Zip Code

21212

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Superintendent of Housing

16b. Kind of Business/Industry

City Government

17. Father's Name (First, Middle, Last)

Lonnie Lorenzo Perry

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Storm

19a. Informant's Name/Relationship (Type, Print)

Anna T. Perry / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

907 E. Lake Avenue Baltimore, MD 21212

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gardens of Faith Cem.

Date

8/6/97

20c. Location - City or Town, State

Overlea, Maryland

21. Signature of Funeral Service Licensee

Dennis Stephen Kenakis

22. Name and Address of Facility

Mitchell-Wiedefeld Home, Inc.  
6500 York Road Baltimore, MD 21212

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

INTRACEREBRAL BLEEDING

Approximate Interval Between Onset and Death

18 HRS

a. Due to (or as a consequence of):

HYPERTENSION

b. Due to (or as a consequence of):

COUMADIN THERAPY

c. Due to (or as a consequence of):

d. STATUS POST CORONARY ARTERY BYPASS GRAFTING

e. STATUS POST ABDOMINAL AORTIC ANEURYSM REPAIR

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis H. Morris

29c. License number

D18406

29d. Date signed (Month, Day, Year)

8-2-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS MORRIS M.D., 7505 OSLER DR. SUITE 409, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23610

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elizabeth W. Palmer

2. Date of Death

Month Day Year

August 4 1997

3. Time of Death

3:10 AM

4a. Facility Name (If not institution, give street and number)

RIDGEWAY MANOR NURSING HOME

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

n/a

Funeral  
Director

5. Social Security Number

219-26-8841

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JAN 21, 1922

9. Birthplace (State or Foreign

County)

KEELINGS VA

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4201 DUVAL AVENUE

10f. Zip Code

21216

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8<sup>th</sup>

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

GEORGE WINBUSH

18. Mother's Name (First, Middle, Maiden Surname)

NANNIE WADE MC LAUGHLIN

19a. Informant's Name/Relationship (Type, Print)

MAMIE HOLMES- DAUG.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

939 N. STRICKER ST., BALTIMORE, MD 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

LOUDON PARK CEM.

Date

8-8-97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

Bladys W. Jones

22. Name and Address of Facility

March F. H. West

4300 Wabash Avenue Baltimore MD 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure  
Cerebrovascular Insufficiency  
Dementia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Geetha Raja MD

29c. License number

D27541

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GEETHA RAJA, 4367 Hollins Ferry Rd, Baltimore MD 21227

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Harrison-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: This law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23611

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary PERRY

2. Date of Death  
Month Day Year

August 3, 1997

3. Time of Death

1:45 pm

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-09-1346

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Sept. 27, 1903 Md.

9. Birthplace (State or Foreign  
Country)

Md.

Usual Residence of Decedent

10e. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

14 S. East Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married  
☐ Widowed ☐ Divorced12. Was Decedent Ever in U.S.  
Armed Forces?1 ☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nanny

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

William Perry

18. Mother's Name (First, Middle, Maiden Surname)

N/A

19. Informant's Name/Relationship (Type, Print)

Lorraine Engles/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14 S. East Avenue, Baltimore, Md. 21224

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Heart of Jesus 8/5/97 Baltimore, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Bernard Dabrowski Funeral Home 2818 E. Baltimore St  
2122423a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Sepsis

Due to (or as a consequence of):

b. Pneumonia

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

4 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

AF2328412-1913

29d. Date signed (Month, Day, Year)

8/3/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Gerri Davis M.D. 9000 Franklin Square Drive Baltimore, Maryland 21237

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: A law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After any autopsies have been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



WRC  
97-4285-510

RICHARD A.  
PALEWICZ

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23612

ITEM:17  
Items 10b, 10c, 10e, 10f 8-14-97 Film G750 W.H. Per F/H

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

1. Decedent's Name (First, Middle, Last)

RICHARD A. PALEWICZ

2. Date of Death  
Month Day Year

AUG. 01, 1997

3. Time of Death

3:34 PM.

4a. Facility Name (If not institution, give street and number)

20 W. BALTIMORE ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE CITY

5. Social Security Number

353 12 9664

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 26, 1927

9. Birthplace (State or Foreign Country)

ILL.

Usual Residence of Decedent

10a. State

ILL.

10b. County

McHenry

10c. City, Town or Location

ARLINGTON HEIGHTS  
Algonquin

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1526 RIDGE 501 Skyline Drive

10f. Zip Code

60004 60102

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married

3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ADMINISTRATIVE JUDGE

16b. Kind of Business/Industry

JUDICIAL

17. Father's Name (First, Middle, Last)

EMIL

PALE PAL

18. Mother's Name (First, Middle, Maiden Surname)

ALFREDA POLD

19a. Informant's Name/Relationship (Type, Print)

LORRAINE SWETONIC/SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 S. PARKWAY, PROSPECT HEIGHTS, ILL.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

ST. ADALBERT CEMETERY AUG. 6, 1997 NILES, ILL.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

EVANS FUNERAL HOME, INC 16000 ANNAPOLIS RD.

BOWIE, MD. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic Cardiovascular disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

AT

HOTEL

27. Manner of Death

1 ☒ Natural

2 ☐ Accident

3 ☐ Suicide

4 ☐ Homicide

5 ☐ Pending Investigation

6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUG. 02, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23613

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNARD POLE

2. Date of Death

AUGUST 4, 1997 12:24 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Saint Joseph Medical Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

5. Social Security Number

216 16 1545

6. Sex

1 ☐ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 15, 1922

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE

10c. City, Town or Location

PHOENIX

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

#2 Greenland Garth

10f. Zip Code

21131

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1/29/4613. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
n/a16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Inspector/Consultant

16b. Kind of Business/Industry

MD St. Labor &  
Industry Licensing &  
Regulation

17. Father's Name (First, Middle, Last)

Bernard Edgar Pole

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Spittel

19a. Informant's Name/Relationship (Type, Print)

Dorothy J. Pole

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

#2 Greenland Garth, Phoenix, MD 21131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Mausoleum

Date

5 Aug.  
1997

20c. Location - City or Town, State

Timonium, MD

21. Signature of Funeral Service Licensee

Bryan W. Clary

22. Name and Address of Facility

Lemmon Funeral Home of Dulaney Valley, Inc.  
10 W. Padonia Rd., Timonium, MD 2109323a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

CORONARY ARTERY DISEASE

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30263

29d. Date signed (Month, Day, Year)

08-04-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS KHOO, M.D. 7620 YORK ROAD, TOWSON, MARYLAND 21204

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23614**  
Certificate of Death

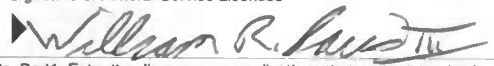
Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last) <b>FREDERICK CURTIS PETTY</b>				2. Date of Death Month <b>07</b> Day <b>29</b> Year <b>1997</b>		3. Time of Death <b>9:35 pm</b>	
4a. Facility Name (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>	
5. Social Security Number <b>452-56-5265</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>58yrs.</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07-04-1939</b>	
9. Birthplace (State or Foreign Country) <b>TEXAS</b>							

Funeral  
Director

To Be Completed by Funeral Director

10a. State <b>MD</b>		10b. County <b>BALTIMORE</b>		10c. City, Town or Location <b>BROOKLANDVILLE</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
10e. Street and Number <b>BOX 763 BROOKLANDVILLE</b>				10f. Zip Code <b>21022</b>		10g. Citizen of What Country? <b>USA</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1961</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MUSIC PROFESSOR</b>		16b. Kind of Business/Industry <b>MUSIC PROFESSOR</b>	
17. Father's Name (First, Middle, Last) <b>DELEATH ORVILLE PETTY</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>FRANCES BROWING</b>			
19a. Informant's Name/Relationship (Type, Print) <b>JOSEPHINE D. JOHNSON (WIFE)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>BOX 763 BROOKLANDVILLE, MD. 21022.</b>			
20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GREEN MOUNT CREMATORY</b>		20c. Location - City or Town, State <b>07/31/97 BALTO., MD.</b>			
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212.</b>			

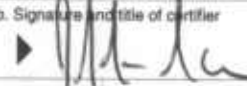
Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		a. <b>HYPOTENSION</b> Due to (or as a consequence of):  b. <b>PULMONARY HYPERTENSION</b> Due to (or as a consequence of):  c. Due to (or as a consequence of):  d.		Approximate Interval Between Onset and Death  <b>1 WEEK</b>  <b>1 YEAR</b>	
--	--	---	--	--	--

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	

25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)  28b. Time of Injury <b>M</b> 28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how Injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	
28f. Location (Street and Number or Rural Route Number, City or Town, State)			

29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 	
29c. License number <b>044560</b>		29d. Date signed (Month, Day, Year) <b>7/30/97</b>	

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>JEFFREY ALEXANDER M.D. 10755 FALLS RD. LUTHERVILLE, MD. 21093.</b>	
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>	

State  
Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23615  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARMELLA M. RICE

2. Date of Death

August 5 1997

3. Time of Death

1:55 AM

4a. Facility Name (If not institution, give street and number)

CHURCH HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE BALTIMORE CITY

4c. County of Death

Funeral  
Director

5. Social Security Number

217-18-2630

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

74

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

July 17, 1923

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

940 S. Lakewood Avenue

10f. Zip Code

21224

10g. Citizen of What Country?

U. S. A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
10th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Thomas J. Azzaro

18. Mother's Name (First, Middle, Maiden Surname)

Mary Culotta

19a. Informant's Name/Relationship (Type, Print)

John D. Rice Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

108 Wellham Avenue, Glen Burnie, Maryland 21061

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Most Holy Redeemer

Date

8/9/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

Schimunek Funeral Home Inc.  
3331 Brehms Lane, Baltimore, Maryland 21213

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SUBARACHNOID HEMORRHAGE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE PULMONARY EDEMA

HYPOXIC ENCEPHALOPATHY

CORONARY ARTERY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

021338

29d. Date signed (Month, Day, Year)

August 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALAN SWEATMAN CHURCH HOSPITAL BALTIMORE MD

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

[Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23616

ITEM: 8 per FH G-750 8-6-97 eoh

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lonnie

Rice

2. Date of Death

Month Day Year

August 01 1997

3. Time of Death

3:00 P.M.

4a. Facility Name (If not institution, give street and number)

Good Samaritan Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-22-1816

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

11-23-26

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1507 Argonne Drive

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Director

16b. Kind of Business/Industry

Corrections penials

17. Father's Name (First, Middle, Last)

Coley Rice

18. Mother's Name (First, Middle, Maiden Surname)

Agnes Williams

19a. Informant's Name/Relationship (Type, Print)

Timothy Rice (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3618 Echodale Ave Balt MD 21214

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Baltimore Cemetery

Date

8/9/97

20c. Location - City or Town, State

Baltimore MD

21. Signature of Funeral Service Licensee

Doretha Hector CFSP

22. Name and Address of Facility

E.L. Phillips

1721-27 N MONROE ST Balt MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Septic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 day

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Left hemothorax

Due to (or as a consequence of):

1 day

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. had Youssef, MD

29c. License number

P10584

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5601 Loch Raven Boulevard Baltimore, MD 21239

J. had Youssef, MD, Good Samaritan Hospital

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

J. had Youssef

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23617

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES F. RICHARDSON

2. Date of Death

August 2, 1997

3. Time of Death

8:30 P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

5. Social Security Number

219-58-5053

6. Sex

XX M 2 F

7. Age (In yrs. last birthday)

83

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

10-09-1913

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MD.

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

XX Yes 2 No

10e. Street and Number

2095 ROCKROSE AVENUE

10f. Zip Code

21211

10g. Citizen of What Country?

U.S.A.

11. Marital Status

XX Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XX No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes XX No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 YEARS

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NONE

16b. Kind of Business/Industry

NONE

17. Father's Name (First, Middle, Last)

JAMES H. RICHARDSON

18. Mother's Name (First, Middle, Maiden Surname)

ANNIE BELL MOUNGER

19a. Informant's Name/Relationship (Type, Print)

JESSIE R. KRATZER (SISTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

401 HULL PLACE, ROCKVILLE, MARYLAND, 20852

20a. Method of Disposition

XX Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

DRUID RIDGE CEMETERY 8-6-97 PIKESVILLE, MD.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

R. H. Ruth

22. Name and Address of Facility

HENRY W. JENKINS AND SONS COMPANY  
4905 YORK ROAD, BALTIMORE, MARYLAND, 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. BILATERAL PNEUMONIA

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

DEMENTIA - SCHIZOPHRENIA

ARTERIOVENOUS CARDIOVASCULAR DISEASE - STROKE

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient 2 ER/Outpatient 3 DOA

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death

1 Natural 5 Pending investigation  
2 Accident 6 Could not be determined  
3 Suicide 4 Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. H. Ruth MD

29c. License number

D19057

29d. Date signed (Month, Day, Year)

August 2/1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

PELAYO E. CORREIA MD

LIBERTY MEDICAL CENTER

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

J. H. Ruth

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please send it to the Department of Health and Mental Hygiene, Baltimore, Maryland 21215-0020.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23618

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Baby Girl Rudolf

2. Date of Death  
Month Day Year  
August 1 1997

3. Time of Death  
8:30 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Greater Baltimore Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

NA

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

8/1/97

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1824 Park Beach Drive

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

NA

College (1-4 or 5+)

NA

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NA

18b. Kind of Business/Industry

NA

17. Father's Name (First, Middle, Last)

NA

18. Mother's Name (First, Middle, Maiden Surname)

Cheryl Rudolf

19a. Informant's Name/Relationship (Type, Print)

GBMC

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6701 North Charles Street, Baltimore, MD 21204

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Green Mount Crematory 8-5

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

James R. Kell

22. Name and Address of Facility

Henry W. Jenkins & Sons  
4905 York Rd., Baltimore, MD 212121

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Acute chorioamnionitis

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe immaturity (22 2/7 weeks gestation)

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day, Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Steven H. Pearlman M.D.

29c. License number

D30206

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Steven H. Pearlman, M.D. GBMC 6701 North Charles St. Baltimore, MD 21204

31. Date filed (Month, Day, Year)

32. Registrar's Signature

▶

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Rudolf, Cheryl



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23619

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Charles W. Reilly Jr</b>				2. Date of Death Month <b>AUGUST</b> Day <b>3</b> Year <b>1997</b>		3. Time of Death <b>4:00 PM</b>		
	4e. Facility Name (If not institution, give street and number) <b>ST. JOSEPH'S HOSPITAL</b>				4b. City, Town, or Location of Death <b>TOWSON</b>		4c. County of Death <b>BALTIMORE</b>		
Funeral Director	5. Social Security Number <b>25-14-8467</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>December 24, 1921</b>		
	9. Birthplace (State or Foreign Country) <b>Pennsylvania</b>		10a. State <b>MD</b>		10b. County <b>NIA</b>		10c. City, Town or Location <b>BALTIMORE, CITY</b>		
Usual Residence of Decedent		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <b>3302 MARY AVE</b>		10f. Zip Code <b>21214</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>U.S.N.A</b> If Yes, Give Year or Dates: <b>1943</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		College (1-4 or 5+) <b>3 yrs.</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>SALES ENGINEER</b>		16b. Kind of Business/Industry <b>Lanier engineer C.O.</b>			
17. Father's Name (First, Middle, Last) <b>Charles W. Reilly Sr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>LENORA FITZGERALD</b>					
19a. Informant's Name/Relationship (Type, Print) <b>MARY ANN Reilly (Wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3302 MARY AVE, BALT, MD 21214</b>					
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem. 8-7-97</b>		20c. Location - City or Town, State <b>BALTIMORE</b>		20d. Date <b>8-7-97</b>			
21. Signature of Funeral Service Licensee <b>Hartley Miller</b>				22. Name and Address of Facility <b>Hartley Miller Funeral Home</b> <b>7527 Harford RD. BALTIMORE MD 21234</b>					
23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cerebral Vascular Accident</b> Due to (or as a consequence of): <b>Diabetic Mellitus, Type II</b> Due to (or as a consequence of): <b>Hypertension</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Hypertension</b>								Approximate Interval Between Onset and Death <b>8 HRS</b>	
Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of injury <b>M</b>	
28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <b>Neal M. Friedlander, M.D. Attending</b>		29c. License number <b>028673</b>		29d. Date signed (Month, Day, Year) <b>8/3/97</b>			
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>NEAL M. FRIEDLANDER, MD 301 ST. PAUL PLACE, SUITE 007 BALTIMORE MD 21202</b>									
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>John Davidson-Randall</b>							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

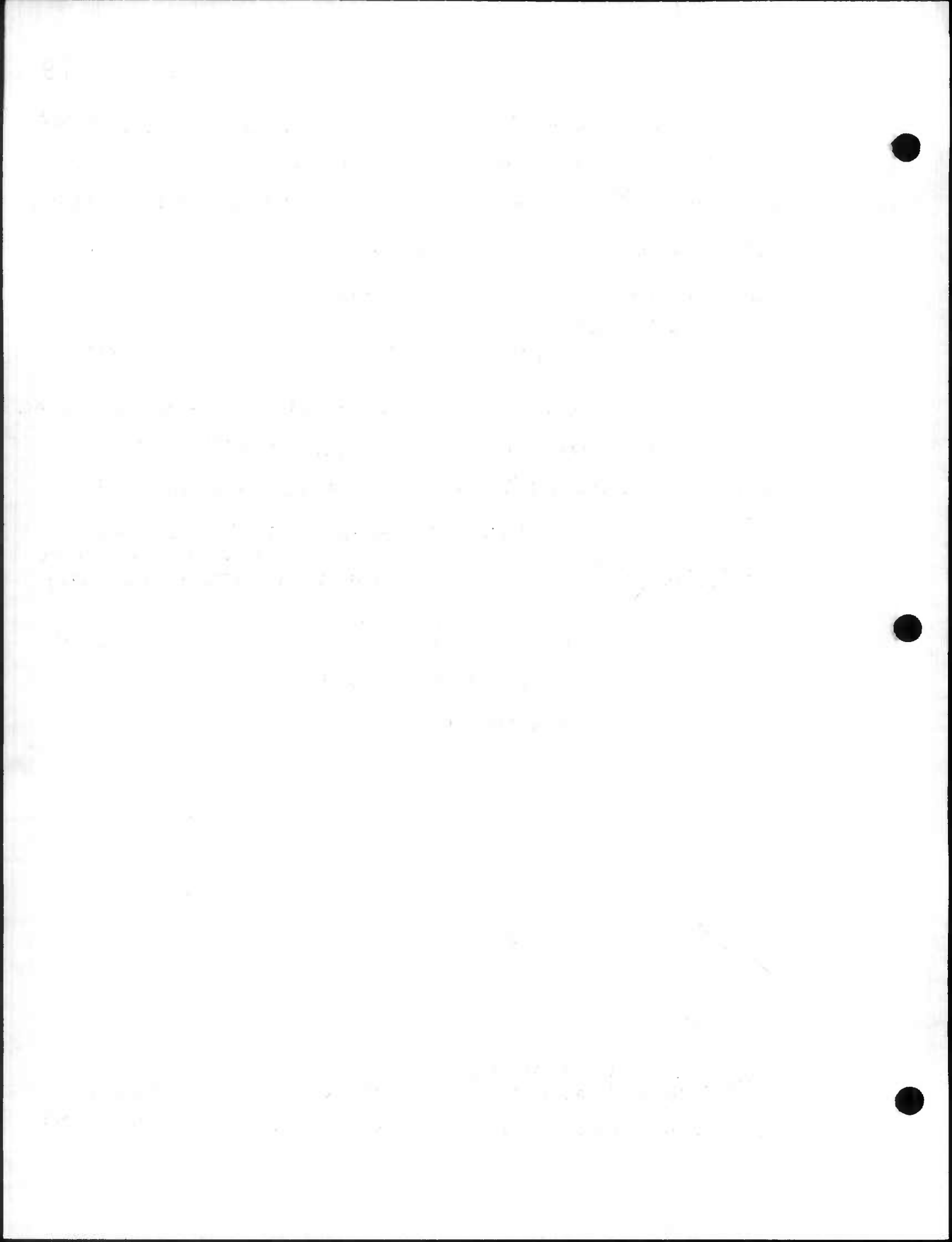
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

9

State  
Registrar



Items: 23a part I, 27 per ME0 G-750 8/22/97 dh

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Patricia E. Ross</b>				2. Date of Death Month Day Year <b>AUG. 1, 1997</b>		3. Time of Death <b>0755 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>1105 CHESTER ROAD</b>				4b. City, Town, or Location of Death <b>ESSEX</b>		4c. County of Death <b>BALTIMORE</b>	
Funeral Director	5. Social Security Number <b>220-48-1292</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>46</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Nov. 8, 1950</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Middle River</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1105 Chester Road</b>		10f. Zip Code <b>21220</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collage (1-4 or 5+) <b>2 yrs</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Nurse</b>		16b. Kind of Business/Industry <b>Health</b>			
	17. Father's Name (First, Middle, Last) <b>Paul J. Goeller</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rita M. Grebe</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Steven Ross/husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1105 Chester Road Baltimore Md. 21220</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus</b>		20c. Date <b>8/5/97</b>		20d. Location - City or Town, State <b>Baltimore Md.</b>	
	21. Signature of Funeral Service Licensee <b>R. Terry Connelly</b>				22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <b>CARDIAC ARRHYTHMIA</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown							
	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No								
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
			28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier <b>[Signature]</b>		29c. License number <b>O.C.M.E</b>		29d. Date signed (Month, Day, Year) <b>AUG. 2, 1997</b>			
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>111 Penn Street, Baltimore, Maryland 21201</b>							
	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>[Signature]</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23621

Item 7 per FH Film G750 8-6-97 rja

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GLORIA SCOTT</b>				2. Date of Death Month <b>AUGUST</b> Day <b>05</b> Year <b>1997</b>		3. Time of Death <b>21:05</b>	
	4a. Facility Name (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				4b. City, Town, or Location of Death <b>BALTIMORE CITY</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-50-0309</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>47</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>6-27-1950</b>	
	9. Birthplace (State or Foreign Country) <b>Md</b>		10a. State <b>Md</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>5335 Cordelia Avenue</b>		10f. Zip Code <b>21215</b>	
	10g. Citizen of What Country? <b>U S A</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th grade</b> College (1-4or 5+) <b>N/A</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Salad Girl</b>				16b. Kind of Business/Industry <b>John H. Country Club</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>James Jackson, Sr</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rosa Mae Barkley</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Donald B. Scott, Sr-Husband</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5335 Cordelia Avenue Baltimore, Md 21215</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Mt Zion Cemetery</b>		20c. Location - City or Town, State <b>8-9-97 Lansdown, Md</b>	
	21. Signature of Funeral Service Licensee <b>Gabrielle Cook</b>				22. Name and Address of Facility <b>March F/H West 4300 Wabash Avenue Baltimore, Md 21215</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>FULMINANT HEPATITIS</b>				Approximate Interval Between Onset and Death <b>TWO WEEKS</b>			
	23a. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>AUTOIMMUNE HEPATITIS</b>				Approximate Interval Between Onset and Death <b>TWO MONTHS</b>			
To Be Completed by Physician/Medical Examiner	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
To Be Completed by Physician/Medical Examiner	29b. Signature and title of certifier <b>[Signature]</b>				29c. License number <b>RES-000</b>			
	29d. Date signed (Month, Day, Year) <b>AUGUST 4, 1997</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>HASITHA M. WICKRAMASINAHE 600 NORTH WOLFE STREET BALTIMORE, MARYLAND 21287</b>			
To Be Completed by Physician/Medical Examiner	31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <b>[Signature]</b>			
	33. State Registrar <b>4</b>				34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23622

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Brioon Stukes

2. Date of Death

August 3 1997

3. Time of Death

8:22AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

NA

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

08-03-97

9. Birthplace (State or Foreign Country)

MD.

Usual Residence of Decedent

10a. State

Md.

10b. County

NA

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2848 Bookert Drive

10f. Zip Code

21225

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Infant

College (1-4 or 5+)

NA

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Child

16b. Kind of Business/Industry

Child

17. Father's Name (First, Middle, Last)

Duron

Stukes

18. Mother's Name (First, Middle, Maiden Surname)

Brandy

Clea

19a. Informant's Name/Relationship (Type, Print)

Brandy Clea/ Wanda Peace

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2848 Bookert Drive Baltimore, Maryland

21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Voshell Mem. Gardens 08-07-97 Dundalk, Md.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

D. Vanecko

22. Name and Address of Facility

Baltimore, Maryland 21202

WM.C. March FH 1101 E. North Avenue

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Congenital Anomalies

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

&lt;1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Gastroschisis

Due to (or as a consequence of):

&lt;1 hour

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Prematurity

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Vanecko

29c. License number

D40247

29d. Date signed (Month, Day, Year)

August 3, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Timothy W. Palmer, MD University of Maryland 225 Greene Street Baltimore MD, 21201

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

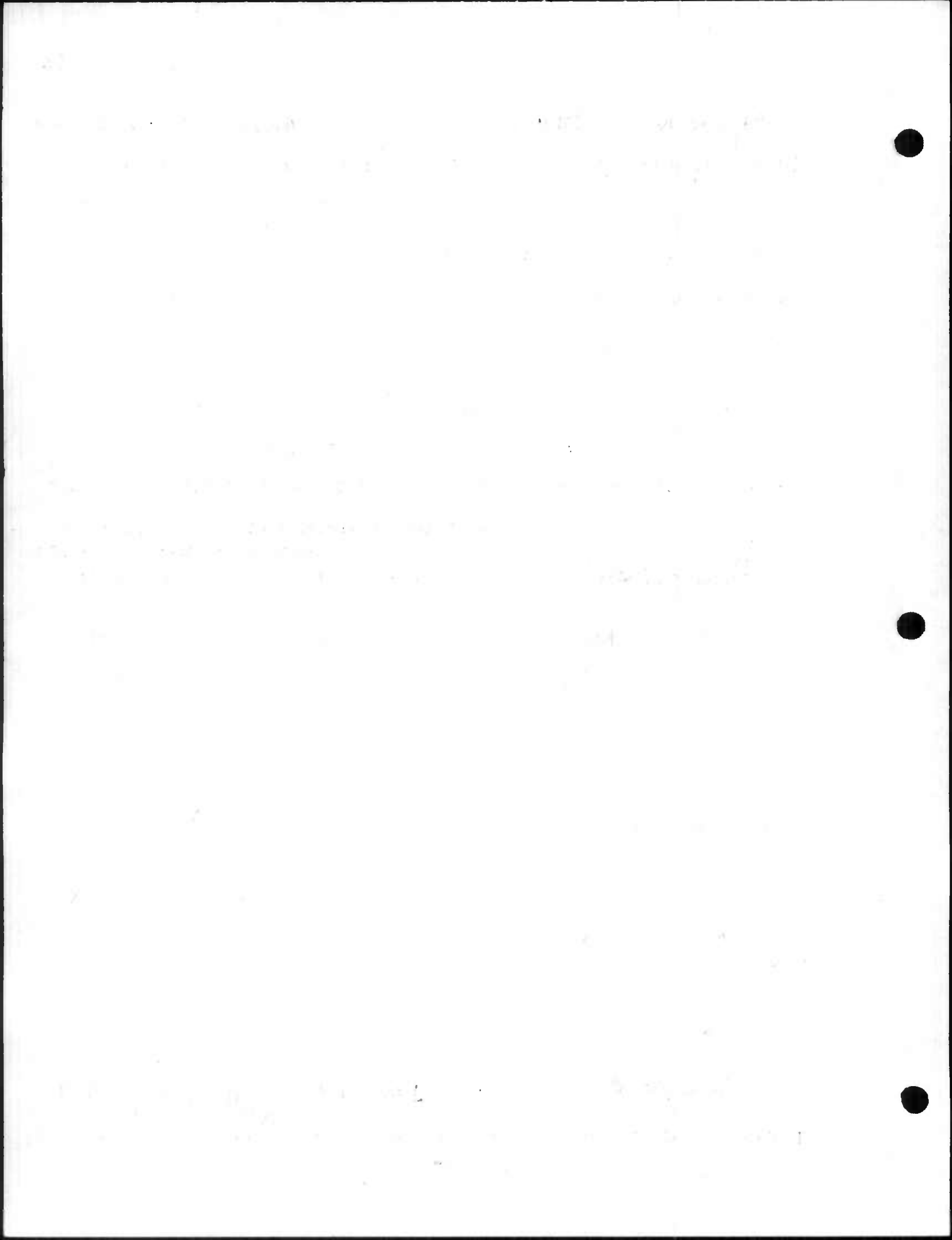
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23623**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin Nutwell SIEGERT

2. Date of Death

August 1, 1997

3. Time of Death

12:34P.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

215-03-6935

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 9, 1917

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4109 Loch Lomond Drive

10f. Zip Code

21236

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: WW II

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Butcher

16b. Kind of Business/Industry

Food Store

17. Father's Name (First, Middle, Last)

Edwin Siegert

18. Mother's Name (First, Middle, Maiden Surname)

Lydia Rogers

19a. Informant's Name/Relationship (Type, Print)

Marie Siegert (wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4109 Loch Lomond Drive, Baltimore, MD 21236

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Parkwood Cemetery

Date

8/4/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Atherosclerotic cardiovascular disease

5 years

Due to (or as a consequence of):

b. Diabetes mellitis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ OOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Julie Casani 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 6 1997

32. Registrar's Signature

Julie Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23624

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joyce Etta Smith

2. Date of Death

Month  
August

Day

4,

Year

1997

3. Time of Death

11:18 PM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

5. Social Security Number

215-14-1821

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
April 11, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

White Marsh

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

5312 Forge Road

10f. Zip Code

21162

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

7th grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William C. Dodd

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Garst

19a. Intendant's Name/Relationship (Type, Print)

Paul E. Smith (husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5312 Forge Road, White Marsh, MD 21162

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pleasant Hill Cemetery

Date

8/7/97

20c. Location - City or Town, State

Monrovia, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Schimunek Funeral Homes, Inc.  
9705 Belair Rd., Baltimore, MD 21236

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Acute intracerebral hemorrhage

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

immediate

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Crossan Donovan M.D.

29c. License number

DO 7632

29d. Date signed (Month, Day, Year)

August 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Crossan Donovan M.D., 2112 DUNDALK AVE., BALTO MD 21222

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John A. ...

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23625

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Sam Series</b>				2. Date of Death Month <b>August</b> Day <b>2</b> Year <b>1997</b>		3. Time of Death <b>9:15 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Mariner Health of Glen Burnie</b>				4b. City, Town, or Location of Death <b>Glen Burnie</b>		4c. County of Death <b>Anne Arundel</b>	
Funeral Director	5. Social Security Number <b>215 01 4485</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>85</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Sept. 13, 1911</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Maryland</b>		10b. County <b>Anne Arundel</b>		10c. City, Town or Location <b>Pasadena</b>	
10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>147 Hillcrest Road</b>		10f. Zip Code <b>21122</b>		10g. Citizen of What Country? <b>U.S.</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Butcher</b>		16b. Kind of Business/Industry <b>Dukeland Packing</b>		17. Father's Name (First, Middle, Last) <b>Meyer Series</b>		
18. Mother's Name (First, Middle, Maiden Surname) <b>Eva Shor</b>		19a. Informant's Name/Relationship (Type, Print) <b>Catherine McClung / daughter</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8417 Miramar Road Pasadena, Maryland 21122</b>		20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		
20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		20c. Date <b>8/6/97</b>		20d. Location - City or Town, State <b>Glen Burnie, Maryland</b>		21. Signature of Funeral Service Licensee <b>Richard E. Davis</b>		
22. Name and Address of Facility <b>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</b>		23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MYOCARDIAL INFARCTION</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		23c. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
23d. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24c. Describe how injury occurred		
24d. Location (Street and Number or Rural Route Number, City or Town, State)		25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>A. Chatterjee</b>		
29c. License number <b>223530</b>		29d. Date signed (Month, Day, Year) <b>8-5-97</b>		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. CHATTERJEE 3927 ANNAPOLIS ROAD 21227</b>		31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		
32. Registrar's Signature <b>Lia Davidson-Randall</b>		33. State Registrar <b>AUG 06 1997</b>		34. State Registrar <b>AUG 06 1997</b>		35. State Registrar <b>AUG 06 1997</b>		

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

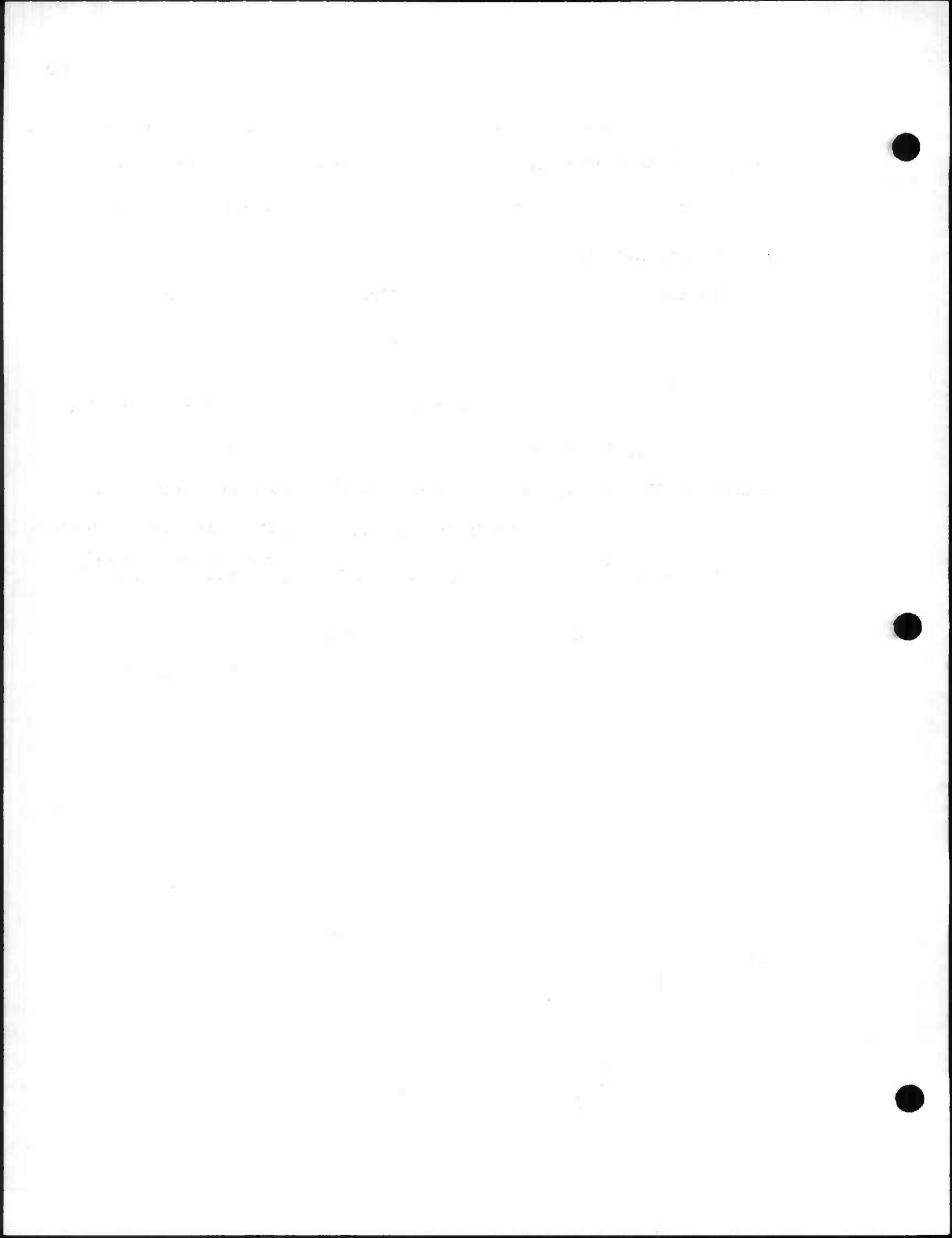
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23626

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <i>Shirley, E. Showe</i>				2. Date of Death Month <i>7</i> Day <i>31</i> Year <i>07</i>				3. Time of Death <i>1830</i>														
	4a. Facility Name (If not institution, give street and number) <i>Univ. of Md Medical System Balto</i>				4b. City, Town, or Location of Death <i>Balto</i>				4c. County of Death <i>N/A</i>														
Funeral Director	5. Social Security Number <i>216 42 5302</i>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <i>52</i> Yrs.		8. Date of Birth (Month, Day, Year) <i>August 24, 1944</i>		9. Birthplace (State or Foreign Country) <i>Maryland</i>														
	Usual Residence of Decedent																						
10a. State <i>Maryland</i>		10b. County <i>Anne Arundel</i>		10c. City, Town or Location <i>Odenton</i>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
10e. Street and Number <i>1460 A Berger Road</i>				10f. Zip Code <i>21113</i>				10g. Citizen of What Country? <i>U.S.</i>															
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <i>White</i>															
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (14 or 5+) <i>College</i>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <i>Home Maker</i>				16b. Kind of Business/Industry <i>Own Home</i>															
17. Father's Name (First, Middle, Last) <i>Edgar Showe</i>				18. Mother's Name (First, Middle, Maiden Surname) <i>Ethel Klipp</i>																			
19a. Informant's Name/Relationship (Type, Print) <i>Robert Kreczmer / son</i>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>208 New York Avenue Pasadena, Maryland 21122</i>																			
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <i>Cedar Hill Cemetery</i>		20c. Date <i>8/4/97</i>		20d. Location - City or Town, State <i>Baltimore, Maryland</i>															
21. Signature of Funeral Service Licensee <i>Jerome Francouche</i>				22. Name and Address of Facility <i>Gonce Funeral Home P.A. 4001 Ritchie Highway Baltimore, Md. 21225</i>																			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																							
<table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><i>myocardial infarction</i></td> <td>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate interval Between Onset and Death         </td> </tr> <tr> <td>b.</td> <td><i>hypotension</i></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> </tr> </table>										Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>myocardial infarction</i>	Due to (or as a consequence of):	Approximate interval Between Onset and Death	b.	<i>hypotension</i>	Due to (or as a consequence of):	c.		Due to (or as a consequence of):	d.		Due to (or as a consequence of):
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a.	<i>myocardial infarction</i>	Due to (or as a consequence of):	Approximate interval Between Onset and Death																			
	b.	<i>hypotension</i>	Due to (or as a consequence of):																				
	c.		Due to (or as a consequence of):																				
	d.		Due to (or as a consequence of):																				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown															
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. Date of Injury (Month, Day Year)		28b. Time of Injury <i>M</i>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No															
				28d. Describe how injury occurred				28e. Location (Street and Number or Rural Route Number, City or Town, State)															
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Jill Turner MD</i>				29c. License number <i>resident RES000</i>															
				29d. Date signed (Month, Day, Year) <i>7/31/97</i>																			
30. Name and address of person who completed cause of death (item 23a) (Type, Print) <i>22 South Greene ST Balto MD 21230</i>																							
31. Date filed (Month, Day, Year) <i>AUG 06 1997</i>				32. Registrar's Signature <i>Lia Anderson-Randall</i>																			

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: At this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23627

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Clarence Scriber

2. Date of Death

Month Day Year  
July 31, 1997

3. Time of Death

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

1190 W. (Belvedere Towers) Northernpk Baltimore

4b. City, Town, or Location of Death

4c. County of Death

N/A

5. Social Security Number

218-05-2411

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Oct. 4, 1916

9. Birthplace (State or Foreign Country)

HOLLYWOOD, MD

Usual Residence of Decedent

10a. State

MD

10b. County

n/a

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

1190 W. NORTHERN PARKWAY #220

10f. Zip Code

21210

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
3 rd

College (14 or 5+)

-

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LONGSHOREMAN

16b. Kind of Business/Industry

STEAMSHIP TRADE ASSO.

17. Father's Name (First, Middle, Last)

JAMES SCRIBER

18. Mother's Name (First, Middle, Maiden Surname)

NETTIE LYLES

19e. Informant's Name/Relationship (Type, Print)

ETHEL SCRIBER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) #220  
1190 W. NORTHERN PKWY., BALTO., MD 21210

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CEDAR HILL CEMETERY 8-4-97 ANNE ARUNDEL Co

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Gabrielle Wood

22. Name and Address of Facility

March F/H West  
4300 Wabash Avenue Baltimore, Md 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Chronic renal failure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Accelerated Hypertension

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Metastatic Lung Cancer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D33977

29d. Date signed (Month, Day, Year)

7/31/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anna Goldberg 6804 Park Heights Ave Balto Md 21215

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Funeral Home: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23628

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>HEATHER M SHAFER</b>				2. Date of Death Month Day Year <b>AUGUST 4 1997</b>		3. Time of Death <b>12:15 pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>BAYVIEW MEDICAL CENTER</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>BALTIMORE CITY</b>	
Funeral Director	5. Social Security Number <b>212-28-9463</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>74</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Feb. 23, 1923</b>	9. Birthplace (State or Foreign Country) <b>Australia</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>Baltimore</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>3911 Foster Avenue</b>				10f. Zip Code <b>21224</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>		16b. Kind of Business/Industry <b>Domestic</b>			
	17. Father's Name (First, Middle, Last) <b>John C. O'Connell</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Montgomery</b>			
Physician /Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Robin Childress/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5346 Wright Avenue, Baltimore, Md. 21205</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Greenmount Cemetery</b>		Date <b>8/5/1997</b>		20c. Location - City or Town, State <b>Baltimore, Md.</b>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Lilly &amp; Zeiler Inc. 700 S. Conkling St./21224</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>COPD</b> Due to (or as a consequence of): <b>PNEUMONIA</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>SEIZURE</b> Due to (or as a consequence of):  Approximate Interval Between Onset and Death <b>10 YEARS</b> <b>4-5 DAYS</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b> <b>Urinary tract infection</b> <b>SEIZURE</b>							
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred			
	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.			
	29b. Signature and title of certifier 				29c. License number <b>RES-000</b>		29d. Date signed (Month, Day, Year) <b>August 4, 1997</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Katherine Widnell, MD JHBMC 4940 Eastern Ave Balt, MD 21224</b>				31. Date (Month, Day, Year) <b>AUG 6 1997</b>			
	32. Registrar's Signature 							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

5





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23629

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) WANDA STEVENSON				2. Date of Death Month Day Year AUG 2 1997		3. Time of Death 12 04 AM	
	4a. Facility Name (If not institution, give street and number) BON SE COURS HOSPITAL				4b. City, Town, or Location of Death BALTIMORE		4c. County of Death N/A	
Funeral Director	5. Social Security Number 217-66-3461		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 41 yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Feb. 29, 1956	9. Birthplace (State or Foreign Country) MD.
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State Md.	10b. County N/A	10c. City, Town or Location Baltimore			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
	10e. Street and Number 122 N. Payson Street				10f. Zip Code 21223		10g. Citizen of What Country? USA	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 11th Grade		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Machine Operator			16b. Kind of Business/Industry Sun Papers		
	17. Father's Name (First, Middle, Last) Calvin Fields				18. Mother's Name (First, Middle, Maiden Surname) Dorothea Stevenson			
To Be Completed by Physician/Medical Examiner	19e. Informant's Name/Relationship (Type, Print) Dorothea Fortune mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 N. Payson Street Balto., Md. 21223			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Western Star Cemetery		Date Aug 9		20c. Location - City or Town, State Balto., Md.	
	21. Signature of Funeral Service Licensee Herbert E. Nutter				22. Name and Address of Facility Nutter Funeral Homes, Inc. 2501 Gwynns Falls PKWY Balto., Md. 21216			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMOCYSTIS PNEUMONIA Acute. Due to (or as a consequence of): Auto immune deficiency synd. chronic							
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown							
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier James R. D.				29c. License number 2-19528		29d. Date signed (Month, Day, Year) 8/2/97		
30. Name and address of person who completed Cause of Death (Using 23a) (Type, Print) John Davidson-Randall				31. Date filed (Month, Day, Year) AUG 06 1997				
32. Registrar's Signature John Davidson-Randall								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23630

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ford L. Stump

2. Date of Death  
Month Day Year

8

2

97

3. Time of Death

0755

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

NA

Funeral  
Director

5. Social Security Number

215-46-9272

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

50

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Oct. 3 1946

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Md.

10b. County

n/a

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1521 Light Street

10f. Zip Code

21230

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

3

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Bricklayer

16b. Kind of Business/Industry

Wayne Stollins  
Masonry Company

17. Father's Name (First, Middle, Last)

Ford William Stump

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Hyphs

19a. Informant's Name/Relationship (Type, Print)

Elizabeth Stump (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1921 E. Lombard Street, Baltimore, Md. 21231

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

Aug. 7 1997

20c. Location - City or Town, State

Brooklyn Park, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

McCully-Polyniak Funeral Home of South Balto.  
130 E. Fort Ave. Baltimore, Md. 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. interstitial lung disease

Due to (or as a consequence of)

Approximate Interval Between Onset and Death

1 month

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. rheumatic heart with mitral stenosis

Due to (or as a consequence of):

1 month

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

MD - 9327

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Robert W. Ross, 22 So. Greene St., Baltimore, MD 21201

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

State  
Registrar

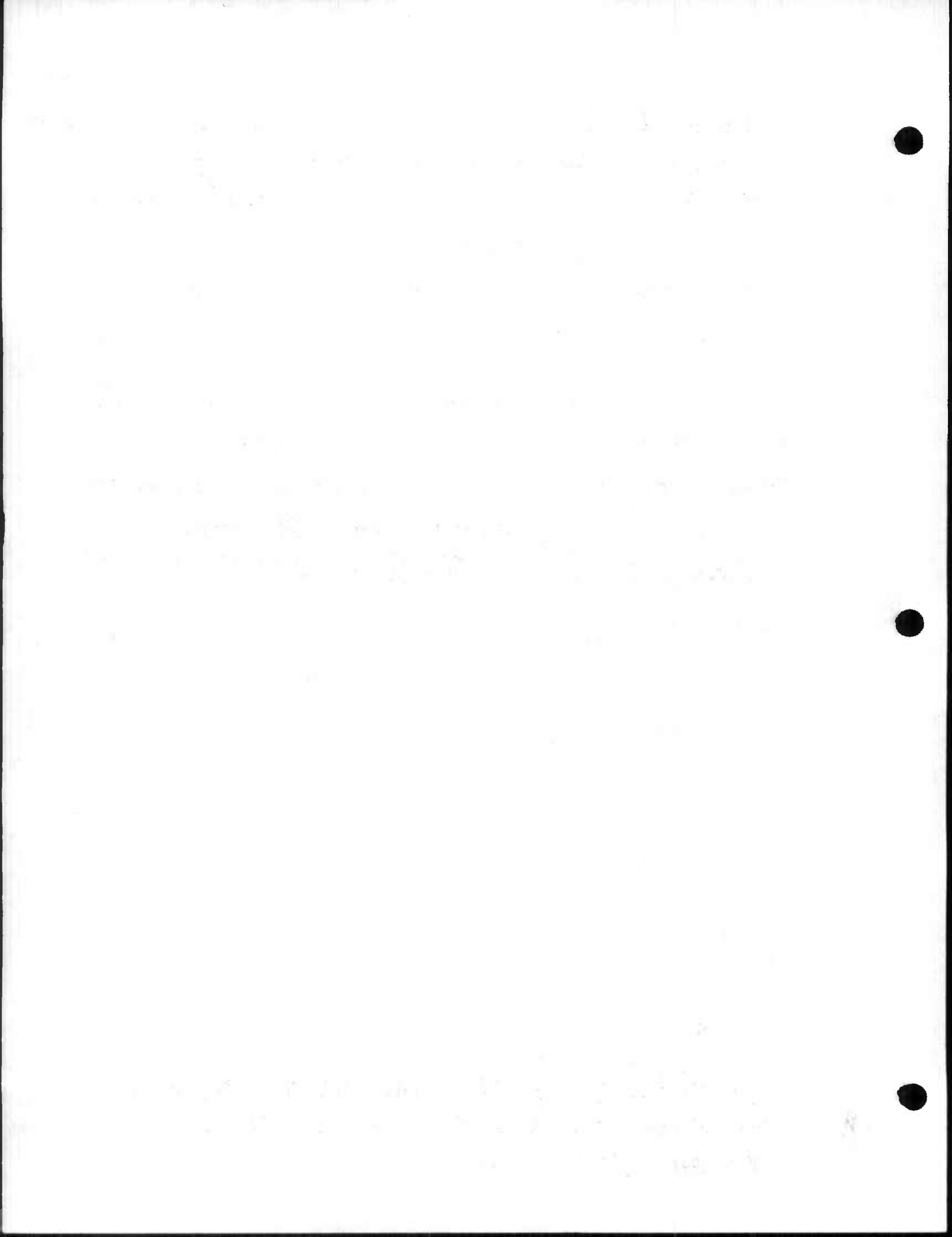
Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23631

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CAROL MARIA SMALL</b>						2. Date of Death Month <b>AUGUST</b> Day <b>1</b> Year <b>1997</b>		3. Time of Death <b>3:52 PM</b>			
	4a. Facility Name (If not institution, give street and number) <b>HOWARD COUNTY GENERAL HOSPITAL</b>						4b. City, Town, or Location of Death <b>COLUMBIA</b>		4c. County of Death <b>HOWARD</b>			
Funeral Director	5. Social Security Number <b>219-26-3548</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>57</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>9/5/39</b>		9. Birthplace (State or Foreign Country) <b>PENNSYLVANIA</b>			
	Usual Residence of Decedent											
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>HOWARD</b>		10c. City, Town or Location <b>ELLICOTT CITY</b>				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number <b>8397 B MONTGOMERY RUN ROAD</b>				10f. Zip Code <b>21043</b>		10g. Citizen of What Country? <b>USA</b>					
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 YEARS</b> Collage (1-4or 5+)				16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>MEDICAL TRANSCRIPTIST</b>			16b. Kind of Business/Industry <b>OWNER</b>				
	17. Father's Name (First, Middle, Last) <b>HENRY N. EBERSOLE</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>ROSE SCHAEFFER</b>							
	19a. Informant's Name/Relationship (Type, Print) <b>JEAN SMALL DAUGHTER</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8555 D FALLS RUN ROAD ELLICOTT CITY, MD 21043</b>							
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>DULANEY VALLEY MEM. GAR.</b>		Date <b>8/5/97</b>		20c. Location - City or Town, State <b>COCKEYSVILLE, MD</b>			
	21. Signature of Funeral Service Licensee <i>Christina L. Kopycz</i>				22. Name and Address of Facility <b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>							
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. CERE BRO VASCULAR ACCIDENT</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>										Approximate Interval Between Onset and Death <b>1 DAY</b>	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No										26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Steven Geller MD</i>				29c. License number <b>134613</b>		29d. Date signed (Month, Day, Year) <b>August 1, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>STEVEN GELLER, MD 9501 OLD ANNAPOLIS ROAD ELLICOTT CITY, MD 21042</b>												
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>				32. Registrar's Signature <i>Gail Davidson-Randall</i>								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23632

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>GERALDINE Smothers</b>					2. Date of Death Month <b>July</b> Day <b>28<sup>th</sup></b> Year <b>1997</b>		3. Time of Death <b>6:30 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Liberty Medical Center</b>					4b. City, Town, or Location of Death <b>Baltimore</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>219-60-1849</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>44</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05/31/1953</b>		9. Birthplace (State or Foreign Country) <b>Virginia</b>
	Usual Residence of Decedent								
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>2441 McCulloh Street</b>				10f. Zip Code <b>21217</b>		10g. Citizen of What Country? <b>U.S.A.</b>		
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>N/A</b>			16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>Gerald Best</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Doris Morton</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Doris Jones</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2441 McCulloh Street, Balto., MD 21217</b>				
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		Date <b>7/30</b>		20c. Location - City or Town, State <b>Baltimore, MD</b>		
	21. Signature of Funeral Service Licensee <i>Leroy O. Dyett</i>				22. Name and Address of Facility <b>LEROY O. DYETT &amp; SON FUNERAL HOME, P.A. 4600 LIBERTY HEIGHTS AVE., BALTO. 21207</b>				
	23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>SEPSIS</b> Due to (or as a consequence of): <b>ACUTE Renal Failure</b> <b>END STAGE AIDS</b> <b>Bilateral PNEUMONIA</b>								Approximate Interval Between Onset and Death
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred	
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Terance L. Lamb M.D.</b>		29c. License number <b>D37203</b>		29d. Date signed (Month, Day, Year) <b>July 28<sup>th</sup> 1997</b>			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>TERANCE L. LAMB M.D. Liberty Medical Center, Baltimore MD 21215</b>									
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		Registrar's Signature <i>John Davidson-Randall</i>							

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23633

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Ronald James Taylor				2. Date of Death Month Day Year August 5 1997		3. Time of Death 6:15 AM																										
	4a. Facility Name (If not institution, give street and number) Doctors' Community Hospital				4b. City, Town, or Location of Death Lanham		4c. County of Death Prince George's																										
Funeral Director	5. Social Security Number 577 44 4631		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 63 Yrs.		8. Date of Birth (Month, Day, Year) March 16, 1934																										
	9. Birthplace (State or Foreign Country) Maryland		10. Usual Residence of Decedent 10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Glenn Dale																										
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 10043 Dubarry Street		10f. Zip Code 20769		10g. Citizen of What Country? United States																										
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: Korea		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White																										
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Operating Engineer		16b. Kind of Business/Industry U.S. Government																												
	17. Father's Name (First, Middle, Last) Alfred E. Taylor Sr.				18. Mother's Name (First, Middle, Maiden Surname) Frances C. Beaver																												
	19a. Informant's Name/Relationship (Type, Print) Dawn E. Taylor Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10043 Dubarry Street Glenn Dale Md 20769																												
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria Virginia																												
	21. Signature of Funeral Service Licensee <i>James R. Brown</i>		22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715																														
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	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <i>Cardiac Arrest</i></td> <td rowspan="4">Approximate Interval Between Onset and Death <i>minutes</i> <i>10 days</i> <i>10 days</i></td> </tr> <tr> <td>b. <i>Respiratory failure</i></td> </tr> <tr> <td>c. <i>Hypoxia encephalopathy</i></td> </tr> <tr> <td>d.</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <i>Cardiac Arrest</i>	Approximate Interval Between Onset and Death <i>minutes</i> <i>10 days</i> <i>10 days</i>	b. <i>Respiratory failure</i>	c. <i>Hypoxia encephalopathy</i>	d.																			
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<table border="1"> <tr> <td colspan="2">25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No</td> <td colspan="6">26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</td> </tr> <tr> <td colspan="2">27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined</td> <td colspan="2">28a. Date of Injury (Month, Day Year)</td> <td colspan="2">28b. Time of Injury M</td> <td colspan="2">28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No</td> <td colspan="2">28d. Describe how injury occurred</td> </tr> <tr> <td colspan="4">28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</td> <td colspan="4">28f. Location (Street and Number or Rural Route Number, City or Town, State)</td> </tr> </table>								25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
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27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred																									
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)																													
<table border="1"> <tr> <td colspan="8">29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</td> </tr> <tr> <td colspan="4">29b. Signature and title of certifier <i>John R. Brown</i></td> <td colspan="2">29c. License number D12962</td> <td colspan="2">29d. Date signed (Month, Day, Year) AUGUST 5, 1997</td> </tr> </table>								29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								29b. Signature and title of certifier <i>John R. Brown</i>				29c. License number D12962		29d. Date signed (Month, Day, Year) AUGUST 5, 1997											
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29b. Signature and title of certifier <i>John R. Brown</i>				29c. License number D12962		29d. Date signed (Month, Day, Year) AUGUST 5, 1997																											
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ZORAYDA LEE LACER MD 8909 OLD BRANCH AVE., CLINTON, MD 20735																																	
31. Date filed (Month, Day, Year) AUG 06 1997		32. Registrar's Signature <i>John Davidson</i>																															

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23634

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Audrey Laura TEWELL</b>				2. Date of Death Month Day Year <b>July 31, 1997</b>		3. Time of Death <b>2:10 P.M.</b>	
	4a. Facility Name (If not institution, give street and number) <b>Franklin Square Hospital Center</b>				4b. City, Town, or Location of Death <b>Rosedale</b>		4c. County of Death <b>Baltimore</b>	
Funeral Director	5. Social Security Number <b>217-16-1989</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>75</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Oct. 12, 1921</b>	
	9. Birthplace (State or Foreign Country) <b>Maryland</b>		10a. State <b>Md.</b>		10b. County <b>Baltimore</b>		10c. City, Town or Location <b>Essex</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>1513 Williams Ave.</b>		10f. Zip Code <b>21221</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> Collage (1-4 or 5+) <b></b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Clerk</b>		16b. Kind of Business/Industry <b>WT Grant</b>			
	17. Father's Name (First, Middle, Last) <b>Edgar R. Shiloh</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Margaret M. Schaffer</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Teresa REilly</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2051 Whiteford Road Whiteford Md. 21160</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery 8/4/97</b>		20c. Location - City or Town, State <b>Baltimore MD.</b>			
	21. Signature of Funeral Service Licenses <b>R. Terry Connelly</b>		22. Name and Address of Facility <b>Connelly Funeral Home of Essex 300 Mace Ave. Baltimore MD. 21221</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Pancreatic tumor</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d. Due to (or as a consequence of):</b>		Approximate Interval Between Onset and Death <b>7 days</b>					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure</b> <b>Poor nutrition</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No					
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>J. Sutton Hamilton MD</b>		29c. License number <b>R D 2329</b>		29d. Date signed (Month, Day, Year) <b>July 31, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dr. Sutton Hamilton 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature <b>Julia Davidson-Randall</b>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The Registrar certifies that the death certificate is executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23635

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellen A. VOLLMER

2. Date of Death

Month Day Year  
August 1, 1997

3. Time of Death

7:50 A.M.

4a. Facility Name (If not institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rosedale

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-16-5523

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 5, 1905

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

231 North Port Street

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8th grade

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Seamstress

16b. Kind of Business/Industry

Clothing Company

17. Father's Name (First, Middle, Last)

John Henry Lehman

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Agnes Roddy

19a. Informant's Name/Relationship (Type, Print)

Richard L. Howlett (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7 Poplar View Road, Delta, PA. 17314

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Woodlawn Cemetery

Date

8/4/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee

Robert J. Madachy

22. Name and Address of Facility

Schimunek Funeral Home of Bel Air, Inc.  
610 W. MacPhail Road, Bel Air, MD. 21014

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pneumonia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

b. Seizure

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Cerebral vascular accident

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. J. S. Rana

29c. License number

R D 1931

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. J. S. Rana 9000 Franklin Square Dr. Baltimore, Maryland 21237

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

4



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23636

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>PEGGY MARIE WESTBROOK</b>				2. Date of Death Month <b>AUGUST</b> Day <b>3</b> Year <b>1997</b>		3. Time of Death <b>12:59 PM</b>																													
	4a. Facility Name (If not institution, give street and number) <b>Saint Joseph Medical Center</b>				4b. City, Town, or Location of Death <b>Towson</b>		4c. County of Death <b>Baltimore</b>																													
Funeral Director	5. Social Security Number <b>215-72-0187</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>41</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>07-31-56</b>																													
	9. Birthplace (State or Foreign Country) <b>Md.</b>		10e. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>Baltimore</b>																													
To Be Completed by Funeral Director	Usual Residence of Decedent				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>																													
	10e. Street and Number <b>1204 Windemere Avenue</b>				10f. Zip Code <b>21218</b>		10g. Citizen of What Country? <b>USA</b>																													
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>																													
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b> College (1-4 or 5+) <b>NA</b>		16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Domestic</b>		16b. Kind of Business/Industry <b>various trades</b>																															
	17. Father's Name (First, Middle, Last) <b>Leroy Arrington</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Audrey Harrison</b>																															
	19a. Informant's Name/Relationship (Type, Print) <b>Michael Westbrook</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21218</b> <b>1204 Windemere Avenue Baltimore, Maryland</b>																															
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Mem. Pk. Cem</b>		20c. Date <b>08-07-97</b>		20d. Location - City or Town, State <b>Randallstown, Md.</b>																													
	21. Signature of Funeral Service Licenses 				22. Name and Address of Facility <b>Baltimore, Maryland 21202</b> <b>WM.C. March FH 1101 E. North Avenue</b>																															
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																			
	<table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)             Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td colspan="6"> <b>RESPIRATORY FAILURE</b>            Due to (or as a consequence of):         </td> <td>Approximate Interval Between Onset and Death <b>DAYS</b></td> </tr> <tr> <td colspan="6"> <b>ADULT RESPIRATORY DISTRESS SYNDROME</b>            Due to (or as a consequence of):         </td> <td><b>DAYS</b></td> </tr> <tr> <td colspan="6"> <b>SEPTIC SHOCK</b>            Due to (or as a consequence of):         </td> <td><b>DAYS</b></td> </tr> <tr> <td colspan="6"> <b>URINARY TRACT INFECTION</b>            Due to (or as a consequence of):         </td> <td><b>DAYS</b></td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>DAYS</b>	<b>ADULT RESPIRATORY DISTRESS SYNDROME</b> Due to (or as a consequence of):						<b>DAYS</b>	<b>SEPTIC SHOCK</b> Due to (or as a consequence of):						<b>DAYS</b>	<b>URINARY TRACT INFECTION</b> Due to (or as a consequence of):					
Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<b>RESPIRATORY FAILURE</b> Due to (or as a consequence of):						Approximate Interval Between Onset and Death <b>DAYS</b>																													
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	<b>SEPTIC SHOCK</b> Due to (or as a consequence of):						<b>DAYS</b>																													
	<b>URINARY TRACT INFECTION</b> Due to (or as a consequence of):						<b>DAYS</b>																													
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		28. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																																		
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		27a. Date of Injury (Month, Day Year)		27b. Time of Injury <b>M</b>		27c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																														
27d. Describe how Injury occurred				27e. Location (Street and Number or Rural Route Number, City or Town, State)																																
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																				
29b. Signature and title of certifier  <b>MD</b>				29c. License number <b>D 31826</b>		29d. Date signed (Month, Day, Year) <b>8-3-97</b>																														
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>RICHARD L. LINTHICUM, M. D. 7620 YORK ROAD, TOWSON, MARYLAND 21204</b>																																				
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>																																				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

4

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23637  
Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>IRENE WHITE</b>				2. Date of Death Month <b>Aug</b> Day <b>4</b> Year <b>1997</b>		3. Time of Death <b>10.17pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>2540 W. LANUALE ST</b>				4b. City, Town, or Location of Death <b>BALTO</b>		4c. County of Death <b>NA</b>	
Funeral Director	5. Social Security Number <b>218-26-7613</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>79</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>4/14/98</b>	9. Birthplace (State or Foreign Country) <b>USC</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>MD</b>		10b. County <b>NA</b>		10c. City, Town or Location <b>BALTIMORE</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>2540 W. LANUALE ST</b>				10f. Zip Code <b>21216</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>BLACK</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH</b> College (1-4or 5+) <b>NA</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>LABORER</b>			16b. Kind of Business/Industry <b>Shoemaker</b>		
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>HENRY DANIELS</b>				18. Mother's Name (First, Middle, Maiden Summa) <b>DORA MAY DANIELS</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>LAWRENCE WHITE SON</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3003 Oakhill AVE BALTIMORE MD 21207</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>King Memorial PK 8/9/97 Randalltown MD</b>		20c. Location - City or Town, State <b>MD</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>ALBERT P. WYLLIE F.H. PH</b> <b>638 N. Gilmore Street BALTO. MD 21247</b>		23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>PANCREATIC CANCER</b> Dua to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>3 months</b>					
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Verifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number <b>D29071</b>		29d. Date signed (Month, Day, Year) <b>8-5-97</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>R. KRISHNAN, MD 821 N. EUTAW ST #305 BALTIMORE 21201</b>								
31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23638

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Rashad Williams

2. Date of Death

Month  
JulyDay  
31Year  
1997

3. Time of Death

4:15 pm

4a. Facility Name (If not institution, give street and number)

Sinai Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

220-47-5240

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

Oct. 24 1944

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
MD

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3921 WABASH AVE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

N/A

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

GLEN WILLIAMS

18. Mother's Name (First, Middle, Maiden Surname)

ARILIA WICKHAM

19a. Informant's Name/Relationship (Type, Print)

ARILIA WICKHAM

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3921 WABASH AVE, BALT, MD, 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation / 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING Memorial

Date

8/5/97

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensee

[Signature]

22. Name and Address of Facility

GARY P. MARSH FUNERAL HOME PA  
270 HANCOCK BLVD BALT, MD, 21224

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Intestinal Infarction

Due to (or as a consequence of):

6h

b. Bowel Obstruction

Due to (or as a consequence of):

12h

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

[Signature] Can Zuckberg MD

29c. License number

D38127

29d. Date signed (Month, Day, Year)

July 31 1997

30. Name and address of person who completed cause of death (item 23a) (Type, Print)

Aaron Zuckberg Sinai Hospital Baltimore MD

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

[Signature] John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23639

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Betty J Watts

2. Date of Death

Month

Day

Year

August 02 1997

3. Time of Death

11:15pm

4a. Facility Name (If not institution, give street and number)

GOOD SAMARITAN HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

219-20-6414

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

3/18/26

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CARNEY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9730 MAGLEDT ROAD

10f. Zip Code

21234

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8th GRADE

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ASSEMBLER

16b. Kind of Business/Industry

BENDIX

17. Father's Name (First, Middle, Last)

EDWARD CRAWFORD

18. Mother's Name (First, Middle, Maiden Surname)

MARY PARISH

19a. Informant's Name/Relationship (Type, Print)

CALVIN G. WATTS

HUSBAND

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9730 MAGLEDT ROAD BALTIMORE, MD 21234

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

METRO CREMATORY, INC.

Date

8/4/97

20c. Location - City or Town, State

CATONSVILLE, MD

21. Signature of Funeral Service Licensee

Christina L. Kopyczk

22. Name and Address of Facility

JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD.

TOWSON, MD 21286

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)Distal Aortic Occlusion  
Due to (or as a consequence of):  
Severe Ischemic Cardiomyopathy  
Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d.Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anoxic Encephalopathy  
Severe COPD  
HTN

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anne Owens MD

29c. License number

P09303

29d. Date signed (Month, Day, Year)

AUGUST 2 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANNE OWENS, GOOD SAMARITAN HOSP, 5601 LOCH RAVEN BLVD, BALTIMORE MD 21239

31. Date filed (Month, Day, Year)

AUG 06 1997

32. Registrar's Signature

John A. Henderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23640

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>JOHN ANDREW WERNER</b>				2. Date of Death Month Day Year <b>AUG. 3, 1997</b>		3. Time of Death <b>1841 PM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>2403 WESTFIELD AVENUE</b>				4b. City, Town, or Location of Death <b>BALTIMORE</b>		4c. County of Death <b>N/A</b>	
Funeral Director	5. Social Security Number <b>214-38-2085</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>55</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>11-10-1941</b>	
	9. Birthplace (State or Foreign Country) <b>MARYLAND</b>		10a. State <b>MD</b>		10b. County <b>N/A</b>		10c. City, Town or Location <b>BALTIMORE</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>2403 WESTFIELD AVE</b>		10f. Zip Code <b>21214</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12yrs.</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>PRINTER</b>				16b. Kind of Business/Industry <b>PRINTING</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>WILBER J. WERNER</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>MAE L. CUNNINGHAM</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>MAE L. WERNER (MOTHER)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2403 WESTFIELD AVE. BALTO., MD. 21214.</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>GARDENS OF FAITH</b>		20c. Location - City or Town, State <b>08/08/97 BALTO., MD.</b>	
	21. Signature of Funeral Service Licensee <i>William R. Davis III</i>				22. Name and Address of Facility <b>HENRY W. JENKINS &amp; SONS CO. 4905 YORK RD. BALTO., MD. 21212.</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Contact Crush of Head</b>						Approximate Interval Between Onset and Death	
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Colon Cancer with metastases Diabetes mellitus</b>						23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No						26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>8/3/97</b>		28b. Time of Injury <b>10K M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	28d. Describe how injury occurred <b>Subject shot self</b>		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>home</b>		28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2403 Westfield Ave 21214</b>		28g. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29e. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29f. Signature and title of certifier <i>John A. [Signature]</i>	
	29g. License number <b>O.C.M.E</b>						29h. Date signed (Month, Day, Year) <b>AUG. 4, 1997</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>John A. [Signature]</b> 111 Penn Street, Baltimore, Maryland 21201						31. Date filed (Month, Day, Year) <b>AUG 06 1997</b>	
	32. Registrar's Signature <i>John A. [Signature]</i>						33. Registrar's Title <b>Registrar</b>	

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23641

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Zella G. Adams

2. Date of Death

July 18, 1997 1300

3. Time of Death

4a. Facility Name (If not institution, give street and number)

LORIE NURSING HOME

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

Funeral  
Director

5. Social Security Number

579-14-2507

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Dec. 8, 1909

9. Birthplace (State or Foreign Country)

Oxon Hill, Md.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

☐ Yes 2 ☐ No

10e. Street and Number

9795 Owen Brown Rd.

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Nathaniel Eugene Hungerford

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Cora Fitzgerald

19a. Informant's Name/Relationship (Type, Print)

Betty L. Nordaas/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

St. Barnabas Epis. Ch. Cem

Date

7/22/97

20c. Location - City or Town, State

Temple Hills, Md.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. UREMIA

DAYS

Due to (or as a consequence of):

b. RENAL FAILURE

WEEKS

Due to (or as a consequence of):

c. PULMONARY EDEMA

DAYS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

STAGE 4 PECCUTUS ULCER

POLYARTRITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Francis Chudian

29c. License number

P 42892

29d. Date signed (Month, Day, Year)

JUL 18 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS CHUDIAN MD 98 N BROADWAY SUITE 307 BALTIMORE MD 21231

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

John Anderson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

4

[illegible]

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23642

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Wayne G. Anderson				2. Date of Death Month Day Year July 21 1997		3. Time of Death 5:20 P.M.	
	4a. Facility Name (If not institution, give street and number) 16885 Prince Frederick Road				4b. City, Town, or Location of Death Hughesville		4c. County of Death Charles	
Funeral Director	5. Social Security Number 029 34 3911		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (in yrs. last birthday) 50 Yrs.	8. Date of Birth (Month, Day, Year) August 8, 1946		9. Birthplace (State or Foreign Country) Massachusetts	
	Usual Residence of Decedent				10a. State Maryland		10b. County Charles	
To Be Completed by Funeral Director	10c. City, Town or Location Hughesville				10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	10e. Street and Number 16885 Prince Frederick Road				10f. Zip Code 20637		10g. Citizen of What Country? United States	
	11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: 1968		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> 2		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Mechanic		16b. Kind of Business/Industry Automotive			
	17. Father's Name (First, Middle, Last) Arthur G. Anderson				18. Mother's Name (First, Middle, Maiden Surname) Gertrude Dupree			
	19a. Informant's Name/Relationship (Type, Print) Gertrude D. Anderson Mother				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12319 Stonehaven Lane Bowie Maryland 20715			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. Location - City or Town, State Alexandria Virginia			
	21. Signature of Funeral Service Licensee <i>Michael L. Bigler</i>		22. Name and Address of Facility Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <i>Atherosclerotic Cardiovascular Disease</i> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of): c. Due to (or as a consequence of): d.							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown								
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospitals: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
		28d. Describe how Injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier <i>Deputy Medical Examiner</i>		29c. License number D46419		29d. Date signed (Month, Day, Year) 7/22/97		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charlene Letchford MD 700 Old Line Centre Waldorf Maryland								
31. Date filed (Month, Day, Year) JUL 24 1997		32. Registrar's Signature <i>John Anderson-Randall</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

14 12 11 10 9 8 7 6 5 4 3 2 1

13 12 11 10 9 8 7 6 5 4 3 2 1

12 11 10 9 8 7 6 5 4 3 2 1

11 10 9 8 7 6 5 4 3 2 1

10 9 8 7 6 5 4 3 2 1

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23643

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ruth Armstrong</b>				2. Date of Death Month <b>July</b> Day <b>22</b> Year <b>1997</b>		3. Time of Death <b>10:48 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Laurel Regional Hospital</b>				4b. City, Town, or Location of Death <b>Laurel</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>579-48-5959</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>82 Yrs.</b>		8. Date of Birth (Month, Day, Year) <b>Aug. 18, 1914</b>	
	9. Birthplace (State or Foreign Country) <b>Unknown</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>13215 Ronehill Drive Beltsville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		10e. Street and Number <b>13215 Ronehill Drive</b>		10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>		16b. Kind of Business/Industry <b>Own Home</b>			
	17. Father's Name (First, Middle, Last) <b>unknown</b>		18. Mother's Name (First, Middle, Maiden Surname) <b>unknown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Charlotte A. Weaver (daughter)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 7/25/1997</b>		20c. Location - City or Town, State <b>Brentwood, Maryland</b>			
	21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>		22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>					
	23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>SEPSIS</b> Due to (or as a consequence of): <b>PHLEBITIS</b> Due to (or as a consequence of): <b>ULINARY TRACT INFECTION</b> Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>DEMENTIA</b>		Approximate Interval Between Onset and Death					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DEMENTIA</b>		23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day, Year) <b>7-23-97</b>	
28b. Time of injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Neil A. Meade M.D.</b>		29c. License number <b>019220</b>		29d. Date signed (Month, Day, Year) <b>7-23-97</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>9811 Mallard Dr. Laurel, Maryland 20708</b>		31. Date filled (Month, Day, Year) <b>JUL 24 1997</b>		32. Registrar's Signature <b>J. Davidson-Rendall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar

1. The first part of the document discusses the importance of maintaining accurate records of all transactions. It emphasizes that proper record-keeping is essential for the integrity of the financial system and for the ability to detect and prevent fraud.

2. The second part of the document outlines the specific procedures for recording transactions. It details the steps involved in the accounting process, from the initial entry of data into the system to the final review and approval of the records.

3. The third part of the document addresses the challenges associated with record-keeping in a complex and rapidly changing environment. It discusses the need for continuous improvement and the importance of staying up-to-date with the latest technologies and best practices.

4. The fourth part of the document provides a summary of the key findings and recommendations. It highlights the areas where further action is needed and offers suggestions for how to improve the record-keeping process.

P. P. 52-7

08.09.19

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23644

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

David Amiel

2. Date of Death

Month  
JulyDay  
11Year  
1997

3. Time of Death

6:06 PM

4a. Facility Name (If not institution, give street and number)

7716 Sebago Rd.

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

215-35-0933

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

14 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

June 14, 1983

9. Birthplace (State or Foreign Country)

Israel

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

7716 Sebago Rd.

10f. Zip Code

20817

10g. Citizen of What Country?

US

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Student

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Valery Dan Amiel

18. Mother's Name (First, Middle, Maiden Surname)

Teresa Korczewski

19a. Informant's Name/Relationship (Type, Print)

Teresa Pollin/ Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7716 Sebago Rd. Bethesda, Md. 20817

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

King David Memorial Gardens 7/13/97 Falls Church, Va.

21. Signature of Funeral Service Listing

22. Name and Address of Facility

Edward Sagel Funeral Direction

1091 Rockville Pike Rockville, Md. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Brain Tumor - astrocytoma

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
Investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

Res-000

29d. Date signed (Month, Day, Year)

July 12, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Anne Comi MD Johns Hopkins Hospital Baltimore MD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23645

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Delmas Littleton Allen				2. Date of Death Month Day Year July 16, 1997		3. Time of Death 7:55 PM	
	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospital				4b. City, Town, or Location of Death Rockville		4c. County of Death Montgomery	
Funeral Director	5. Social Security Number 218-38-5645		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) Feb. 3, 1908	
	9. Birthplace (State or Foreign Country) Tennessee		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg	
10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 19522 Divot Place		10f. Zip Code 20879		10g. Citizen of What Country? United States		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: white		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 3		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Claims Administrator		16b. Kind of Business/Industry General Accounting Office				
17. Father's Name (First, Middle, Last) William Sherman Allen				18. Mother's Name (First, Middle, Maiden Surname) Rosa Elizabeth Mills				
19a. Informant's Name/Relationship (Type, Print) Della S. Allen				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10				
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State 7-19-97 Rockville, Maryland				
21. Signature of Funeral Service Licensee Ellen H. Rapp				22. Name and Address of Facility Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Central Nervous System Hemorrhage Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
Approximate Interval Between Onset and Death 3 days								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year) July 13, 1997		28b. Time of Injury Unknown M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		
		28d. Describe how injury occurred Fell off ramp while in wheelchair		28e. Location (Street and Number or Rural Route Number, City or Town, State) 19522 Divot Place, Gaithersburg, MD				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier John F. Tauber		29c. License number D08546		29d. Date signed (Month, Day, Year) July 18, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John F. Tauber, M. D., 8218 Wisconsin Avenue, #318, Bethesda, MD 20814								
31. Date filed (Month, Day, Year) JUL 21 1997		32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



CMK

ROBERT W. ALLEN

Item 5 8-14-97 Film G-750 W.H. Per F/H  
Items: 23a part 1, 2, 28a-f per MEO G-750 8/11/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23646

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT WAYMAN ALLEN

2. Date of Death

Month Day Year  
JULY 21, 1997

3. Time of Death

0345AM

4a. Facility Name (If not institution, give street and number)

ST. AGNES HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

BALTIMORE CITY

Funeral  
Director

5. Social Security Number

218-06-8388

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

27

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 3, 1970

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Clarksville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

12713 Chapel Chase Drive

10f. Zip Code

21029

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Unemployed

16b. Kind of Business/Industry

None

17. Father's Name (First, Middle, Last)

Ronald Roy Allen

18. Mother's Name (First, Middle, Maiden Surname)

Margaret N. Fournier

19a. Informant's Name/Relationship (Type, Print)

Mr. &amp; Mrs. Ronald Allen (parents) 12713 Chapel Chase Dr., Clarksville, MD 21029

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Springfield Cemetery

Date

7/24/97

20c. Location - City or Town, State

Sykesville, MD

21. Signature of Funeral Service Licensee

Brian A. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)  
Sykesville, MD 21784 (410)-795-140023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. MIXED DRUG INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☒ Unknown24e. Was an autopsy  
performed?☒ Yes ☐ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☒ Yes ☐ No25. Was case referred to medical  
examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient☒ ER/Outpatient☐ DOA

26. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☐ Natural ☒ Pending  
Investigation  
☐ Accident ☒ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)

7/21/97 found

28b. Time of  
Injury

2:36 found

28c. Injury at  
Work?☐ Yes ☒ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)  
found in house

28d. Describe how injury occurred

subject ingested drugs

28f. Location (Street and Number or Rural Route Number,  
City or Town, State) 5906 Franklin Avenue,  
Woodlawn, Maryland29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 21, 1997

30. Name and address of person who completed cause of death (Item 28e) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John Andrew Radell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



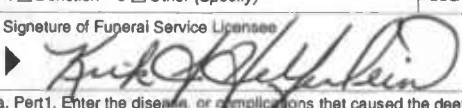
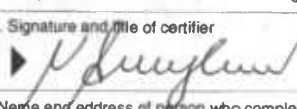
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23647

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <u>Samantha Caleb Renee Baumann</u>				2. Date of Death Month <u>07</u> Day <u>23</u> Year <u>1997</u>		3. Time of Death <u>16:06</u>	
	4a. Facility Name (If not institution, give street and number) <u>UNIVERSITY OF MARYLAND MEDICAL SYSTEM</u>				4b. City, Town, or Location of Death <u>BALTIMORE</u>		4c. County of Death <u>Baltimore City</u>	
Funeral Director	5. Social Security Number <u>215-43-5180</u>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <u>2</u> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <u>December 2, 1994</u>	9. Birthplace (State or Foreign Country) <u>Maryland</u>
	Usual Residence of Decedent				10a. State <u>Maryland</u>		10b. County <u>Kent</u>	
To Be Completed by Funeral Director	10c. City, Town or Location <u>Chestertown</u>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number <u>159 Flatland Road</u>	
	10f. Zip Code <u>21620</u>				10g. Citizen of What Country? <u>U.S.A.</u>		11. Marital Status <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
	12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:				13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <u>White</u>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)		16b. Kind of Business/Industry	
	17. Father's Name (First, Middle, Last) <u>Christopher Gottfried Baumann</u>				18. Mother's Name (First, Middle, Maiden Surname) <u>Wendy Lee Frock</u>			
	19a. Informant's Name/Relationship (Type, Print) <u>Christopher G. Baumann/Father</u>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>159 Flatland Road, Chestertown, Maryland 21620</u>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <u>Chesapeake Cremation Center, LLC</u>		20c. Location - City or Town, State <u>Stevensville, Maryland</u>	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <u>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A.</u> <u>130 Speer Road, Chestertown, Maryland 21620</u>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) e. <u>LOW CARDIAC OUTPUT</u> Due to (or as a consequence of): b. <u>FONTAN PROCEDURE</u> Due to (or as a consequence of): c. <u>SILMONOWITZ ATRESIA</u> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <u>M</u>		
28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier  M. J.		29c. License number <u>244136</u>		
29d. Date signed (Month, Day, Year) <u>7/23/97</u>				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <u>MONIQUE BELLEFLEUR, MD</u> <u>33 SOUTH GLENE</u> <u>BALTIMORE MD 21201</u>				
31. Date filed (Month, Day, Year) <u>JUL 25</u>				32. Registrar's Signature 				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23648

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN EDWARD BOWDEN

2. Date of Death

Month Day Year  
July 20, 1997

3. Time of Death

11:20 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Gladys Spellman Nursing Home

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

237-42-4800

6. Sex

XX M 2 ☐ F

7. Age (In yrs. last birthday)

63 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
05/30/34

9. Birthplace (State or Foreign Country)

Greensboro NC

Usual Residence of Decedent

10a. State

Maryland Prince George

10b. County

10c. City, Town or Location

Oxon Hills

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

502 Wilsonbridge Drive

10f. Zip Code

20745

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
9th

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Grounds Keeper

16b. Kind of Business/Industry

National Airport

17. Father's Name (First, Middle, Last)

Clarence I. Bowden

18. Mother's Name (First, Middle, Maiden Surname)

Mary Forster

19a. Informant's Name/Relationship (Type, Print)

Roy E. Bowden - Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8904 Gypsy Lane, Clinton, MD 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt. Olive Cemetery

Date

7/28/97 Washington, DC

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Atlantis Long Funeral Services  
5948 Addison Rd. Seat Pleasant, MD 2074323a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. RESPIRATORY FAILURE

Due to (or as a consequence of):

b. SEPTICEMIA - RECURRENT

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) LastApproximate  
Interval Between  
Onset and Death

&gt; 3 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DECUBE ULCERS.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D-34525

29d. Date signed (Month, Day, Year)

07-21-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.J. RAO, MD 4000 - Mitchellville Road; #220; Bowie MD 20716.

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

John A. Russell

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23649

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>THOMAS BORDERS</b>				2. Date of Death Month <b>JULY</b> Day <b>16</b> Year <b>1997</b>		3. Time of Death <b>10:46 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>PRINCE GEORGES HOSPITAL CENTER</b>				4b. City, Town, or Location of Death <b>CHEVERLY</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>577-42-1969</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>63</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>12/30/33</b>	9. Birthplace (State or Foreign Country) <b>Atlanta, Ga.</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Md.</b>		10b. County <b>P.G.</b>		10c. City, Town or Location <b>Seat Pleasant</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>7002 Greig Ct. # 102</b>				10f. Zip Code <b>20743</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>'52-'54</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Custodian</b>			16b. Kind of Business/Industry <b>P.G. Co. School System</b>		
	17. Father's Name (First, Middle, Last) <b>Thomas M. Borders, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Euphemia Whitehead</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Sharon D. Borders/Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7767 Riverdale Rd. # 203, New Carrollton, Md. 20784</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cheltenham Vet's. Cem. 7/23/97 Cheltenham, Md.</b>		20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>H.S. WASHINGTON &amp; SONS, INC. 4211 BLAUGHER AVE, N.E.</b>			
	23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of):							
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>b. _____ Due to (or as a consequence of):</b> <b>c. _____ Due to (or as a consequence of):</b> <b>d. _____</b>							
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE</b> <b>CANCER OF PROSTATE</b>						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown	
							24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
							24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No	
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
28d. Describe how injury occurred						28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier 				29c. License number <b>D 33254</b>		29d. Date signed (Month, Day, Year) <b>JULY 17, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>MARIO F. GOLIE JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>								
31. Date filed (Month, Day, Year) <b>JUL 21 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23650

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sesinando B. Basilio				2. Date of Death Month Day Year July 17 1997		3. Time of Death 2:35 AM	
	4a. Facility Name (If not institution, give street and number) Ft. Washington Hospital				4b. City, Town, or Location of Death Ft. Washington		4c. County of Death Prince George's	
Funeral Director	5. Social Security Number 214-04-0361		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 75 Yrs.		8. Date of Birth (Month, Day, Year) July 16, 1922	
	9. Birthplace (State or Foreign Country) Philippine Is.		10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Oxon Hill	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number 203 Loureiro Lane		10f. Zip Code 20745	
	10g. Citizen of What Country? U.S.A.				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Filipino		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Groundskeeper				16b. Kind of Business/Industry Grace Brethren Church			
Physician /Medical Examiner	17. Father's Name (First, Middle, Last) Esteban Basilio				18. Mother's Name (First, Middle, Maiden Surname) Genoveva Betiong			
	19a. Informant's Name/Relationship (Type, Print) Jun Basilio/Son				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7904 Carey Branch Dr., Ft. Washington, Md. 20744			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Resurrection Cemetery		20c. Location - City or Town, State Clinton, Md.	
	21. Signature of Funeral Service Licensee <i>George P. Kalas</i>				22. Name and Address of Facility George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <i>Pneumonia</i> Due to (or as a consequence of): b. <i>Metastatic Renal Carcinoma</i> Due to (or as a consequence of): c. Due to (or as a consequence of): d.				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how Injury occurred			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <i>Keith Bantam, MD</i>			
To Be Completed by Physician/Medical Examiner	29c. License number D36562				29d. Date signed (Month, Day, Year) 7/18/97			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keith Bantam, M.D. 1328 Southern Ave. SE #500 Washington D.C. 20032				31. Date filed (Month, Day, Year) JUL 21 1997			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>Johi Anderson-Robert</i>				33. Registrar's Name Johi Anderson-Robert			
	34. Registrar's Title Registrar				35. Registrar's Address 1328 Southern Ave. SE #500 Washington D.C. 20032			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23651

## Certificate of Death

Reg. No.

10 0/10

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

WILLYE BROWN

2. Date of Death

Month July Day 17 Year 1997

3. Time of Death

9:50AM

4a. Facility Name (If not institution, give street and number)

GREATER LAUREL HOSPITAL

4b. City, Town, or Location of Death

LAUREL

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

579-42-7457

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 15, 1910

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, D.C.

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4022 Meade Street, N.E.

10f. Zip Code

20019

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Day Care Provider

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

Alexander Watson

18. Mother's Name (First, Middle, Maiden Surname)

Louvenia Florence

19a. Informant's Name/Relationship (Type, Print)

Elaine Heath (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7009 Scotch Drive, Laurel, Maryland 20707

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Lincoln Memorial Cemetery

Date

7/23/97

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

M859

22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

2617 Pennsylvania Avenue, SE DC 20020

23a. Part I. Enter the disease, or combination of diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Due to (or as a consequence of):

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

036716

29d. Date signed (Month, Day, Year)

7/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANDREW KUNDAUT M.D. 8317 Cherry Lane Laurel, Md. 20707

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

John Andrew Runkle

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

101 31 1931

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Cleveland Brown Jr.				2. Date of Death Month Day Year JULY 18, 1997		3. Time of Death 1950PM			
	4a. Facility Name (If not Institution, give street and number) ST. JOSEPH'S HOSPITAL E.R.				4b. City, Town, or Location of Death TOWSON		4c. County of Death BALTIMORE COUNTY			
Funeral Director	5. Social Security Number 579-78-5983		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 42 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) 12-19-54	9. Birthplace (State or Foreign Country) Washington DC		
	Usual Residence of Decedent									
10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Capitol Heights			10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
10e. Street and Number 6701 Arlene Drive				10f. Zip Code 20734		10g. Citizen of What Country? USA				
11. Marital Status 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black				
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th				18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Laborer		16b. Kind of Business/Industry Private				
17. Father's Name (First, Middle, Last) Cleveland Brown Sr.				18. Mother's Name (First, Middle, Maiden Surname) Julia Mingo						
19a. Informant's Name/Relationship (Type, Print) Angela Brown Mathis/Sister				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6701 Arlene Drive, Capitol Heights, Maryland 20734						
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Date 7/23/97		20c. Location - City or Town, State Landover, Maryland				
21. Signature of Funeral Service Licensee Nancy A. Perentse				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785						
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Pulmonary Thrombo-embolism Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last									Approximate Interval Between Onset and Death	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Paranoid schizophrenia						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown				
						24a. Was an autopsy performed? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.										
29b. Signature and title of certifier Dennis J. Chute				29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) JULY 19, 1997				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dennis J. Chute, MD 111 Penn Street, Baltimore, Maryland 21201										
31. Date filed (Month, Day, Year) JUL 22 1997				32. Registrar's Signature John Davidson-Randall						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23653

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Delsie H. Bakhsh</b>				2. Date of Death Month <b>07</b> Day <b>18</b> Year <b>97</b>		3. Time of Death <b>3:40am</b>	
	4a. Facility Name (If not institution, give street and number) <b>Doctor's Community Hospital</b>				4b. City, Town, or Location of Death <b>Lanham</b>		4c. County of Death <b>Prince George</b>	
Funeral Director	5. Social Security Number <b>077-82-6604</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>66</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Days	8. Date of Birth (Month, Day, Year) <b>Feb. 22, 1931</b>	9. Birthplace (State or Foreign Country) <b>Pakistan</b>	
	Usual Residence of Decedent							
10e. State <b>Maryland</b>		10b. County <b>Prince George</b>		10c. City, Town or Location <b>Greenbelt</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
10e. Street and Number <b>6006 Spring Hill Dr. #102</b>				10f. Zip Code <b>20770</b>		10g. Citizen of What Country? <b>USA</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>Asian</b>	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>			16b. Kind of Business/Industry <b>Own Home</b>	
17. Father's Name (First, Middle, Last) <b>Theolplus William</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hashmat Un-avail.</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Rev. Harrison Bakhsh</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6006 Spring Hill Dr. #102, Greenbelt, Md. 20770</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>George Washington</b>		20c. Location - City or Town, State <b>7/21/97 Adelphi</b>		
21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Jordan Funeral Service, Inc. 4001 Benning Rd., N.E. (Wash., D.C. 20019)</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Respiratory Collapse</b> Due to (or as a consequence of): <b>Pneumonia</b> Due to (or as a consequence of): <b>Aspiration</b> Due to (or as a consequence of):								Approximate Interval Between Onset and Death
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Stroke (Cerebral Vascular Accident)</b> <b>Coronary Artery Disease</b>								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28d. Describe how injury occurred		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>Kevin H. Scott</b>				
				29c. License number <b>D38534</b>		29d. Date signed (Month, Day, Year) <b>7/19/97</b>		
30. Name and address of person who completed cause of death (Item 29a) (Type, Print) <b>Kevin H. Scott 7725 Belle Point Dr Greenbelt MD 20770</b>								
31. Date filed (Month, Day, Year) <b>JUL 23 1997</b>				32. Registrar's Signature <b>John Andrew Randall</b>				

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

(4)

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23654

Item 12 Per FH Film G753 11-12 *Certificate of Death*

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>George E. Bauer</b>			2. Date of Death Month <b>July</b> Day <b>22</b> Year <b>1997</b>		3. Time of Death <b>5:00 P.M.</b>		
	4a. Facility Name (If not institution, give street and number) <b>Bowie Health Center</b>			4b. City, Town, or Location of Death <b>Bowie</b>		4c. County of Death <b>Prince George's</b>		
Funeral Director	5. Social Security Number <b>215 26 3439</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>66</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Dec. 31, 1930</b>	
	9. Birthplace (State or Foreign Country) <b>Missouri</b>		10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Bowie</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			10e. Street and Number <b>4715 Ramsgate Lane</b>		10f. Zip Code <b>20715</b>		
	10g. Citizen of What Country? <b>United States</b>			11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>51-53</b> If Yes, Give Year or Dates:		
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4or 5+)		
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Cartographer</b>			16b. Kind of Business/Industry <b>Defense Mapping Agency</b>		17. Father's Name (First, Middle, Last) <b>George F. Bauer</b>		
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>May J. Brightman</b>			19a. Informant's Name/Relationship (Type, Print) <b>Patricia M. Bauer Wife</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4715 Ramsgate Lane Bowie Maryland 20715</b>		
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Resurrection Cemetery July 25, 1997 Clinton Maryland</b>		20c. Location - City or Town, State		
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <i>Michael L. Big...</i>			22. Name and Address of Facility <b>Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Md. 20715</b>		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Cardiac arrhythmia</b> Due to (or as a consequence of): <b>Systemic amyloidosis</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last <b>Anemia</b> Due to (or as a consequence of):		
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		
	28a. Date of Injury (Month, Day, Year)			28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred			28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)		
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. Signature and title of certifier <i>J. M. O.</i>		29c. License number <b>D33979</b>		
To Be Completed by Physician/Medical Examiner	29d. Data signed (Month, Day, Year) <b>7/24/97</b>			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>7350 Van Buren Rd Laurel MD 20707</b>		31. Date filed (Month, Day, Year) <b>JUL 24 1997</b>		
	32. Registrar's Signature <i>John Anderson-Randall</i>			33. State Registrar		34. State Registrar		

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23655

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) JOHN SYLVESTER BOWIE				2. Date of Death Month Day Year JULY 19, 1997		3. Time of Death 8:50 AM			
	4a. Facility Name (If not institution, give street and number) FORT WASHINGTON HOSPITAL				4b. City, Town, or Location of Death FORT WASHINGTON PRINCE GEORGES		4c. County of Death			
Funeral Director	5. Social Security Number 578-16-8809		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	7. Age (In yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Oct. 23 1911	9. Birthplace (State or Foreign Country) Wash., DC		
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Fort Washington		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	10e. Street and Number 309 Lourdes Drive				10f. Zip Code 20744		10g. Citizen of What Country? U.S.A.			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Collega (1-4or 5+) 9th		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Construction		16b. Kind of Business/Industry Private					
	17. Father's Name (First, Middle, Last) Walter Bowie				18. Mother's Name (First, Middle, Maiden Surname) Rosalee Humphrey					
	19a. Informant's Name/Relationship (Type, Print) Geraldine Chase/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Lourdes Dr., Ft. Washington, Md 20744					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Harmony Memorial Park		Data 7/25/97		20c. Location - City or Town, State Landover, Md.			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover, Maryland 20785					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Pneumonia - Bacterial</u> Due to (or as a consequence of): b. _____ Due to (or as a consequence of): c. _____ Due to (or as a consequence of): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown			
						24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				
						24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred		
		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier 		29c. License number 036562		29d. Date signed (Month, Day, Year) 7/21/97				
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Keith Banton 1328 Southern Avenue, Suite 308, Wash., DC 20032										
31. Date filed (Month, Day, Year) JUL 24 1997		32. Registrar's Signature 								

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

2/10/14

WEDNESDAY 26 FEB 1914

Went to the bank and paid the bill

and then to the office

and then to the bank

and then to the office

and then to the bank

and then to the office

and then to the bank

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and then to the bank

and then to the office

and then to the bank

and then to the office

W. J. M. 1914

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23656

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Winston Barclay

2. Date of Death  
Month Day Year

July 23, 1997

3. Time of Death

2:15 AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

5. Social Security Number

213-62-8849

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
08-02-31

9. Birthplace (State or Foreign Country)

Trinidad, W.I.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Upper Marlboro

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

12701 Water Fowl Way

10f. Zip Code

20772

10g. Citizen of What Country?

Trinidad, West Indies

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3+

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Entrepreneur

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

James Armstrong Barclay

18. Mother's Name (First, Middle, Maiden Surname)

Alberta Noreiga

19a. Informant's Name/Relationship (Type, Print)

Gwen McCave/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12701 Water Fowl Way, Upper Marlboro, MD 20772

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Crematory

Date

7/29/97

20c. Location - City or Town, State

Beltsville, MD

21. Signature of Funeral Service Licensee

Nancy A. Perentis

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

MANY YEARS

MANY YEARS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attending physician

29c. License number

DA1715

29d. Date signed (Month, Day, Year)

7-23-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

7343-A HANOVER PARKWAY GREENBELT MD 20770

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

Shirley A. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23657

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Thomasine Bingham				2. Date of Death Month Day Year July 18, 1997		3. Time of Death 7:55 PM			
	4a. Facility Name (If not institution, give street and number) Pineview Nursing & Rehab Center				4b. City, Town, or Location of Death Clinton		4c. County of Death Prince George's			
Funeral Director	5. Social Security Number 579-40-3471		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 91 Yrs.		8. Date of Birth (Month, Day, Year) June 22, 06		9. Birthplace (State or Foreign Country) Washington DC	
	Usual Residence of Decedent									
To Be Completed by Funeral Director	10a. State Maryland		10b. County Prince George's		10c. City, Town or Location Clinton				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number 9106 Pineview Lane				10f. Zip Code 20735		10g. Citizen of What Country? USA			
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: Black			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker				16b. Kind of Business/Industry Private	
	17. Father's Name (First, Middle, Last) Frank Spriggs				18. Mother's Name (First, Middle, Maiden Surname) Alberta Florence Contee					
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) Marlena Ellis/Daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17214 Clairfield Lane, Upper Marlboro, MD 20772					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Arlington National Cem.		Date 7/24/97		20c. Location - City or Town, State Arlington, Virginia	
	21. Signature of Funeral Service Licensee Nancy A. Perantoni				22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. status epilepticus Due to (or as a consequence of): b. hypoxia Due to (or as a consequence of): c. pneumonia Due to (or as a consequence of): d. Aneurysm								Approximate Interval Between Onset and Death 10 days	
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Advanced RA Periodicity								23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how Injury occurred	
	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier Abul Hasan Ansari		29c. License number D24208		29d. Date signed (Month, Day, Year) 7-22-97			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) ABUL HASAN O ANSARI				8926 Woodywood Rd #101 Clinton Md. 20731					
	31. Date filed (Month, Day, Year) JUL 24 1997		32. Registrar's Signature John Anderson-Randall							

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97 23658

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARRIE LOU BRATTEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 18 1997</b>		3. TIME OF DEATH <b>22:10 HR</b>	
4. SOCIAL SECURITY NUMBER <b>409-24-7406</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>July 14, 1910 Tennessee</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>424 S. Philadelphia Rd</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Aberdeen</b>		9c. COUNTY OF DEATH <b>Harford</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>424 South Philadelphia Blvd. Room 11</b>				10f. ZIP CODE <b>21001</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>In home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin F. Nichols</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Thompson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William F. Bratten (son)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Room 11 424 S. Phila. Blvd., Aberdeen, MD 21001</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>R. A. Ferris &amp; Co., Inc. 7/21/97</b>		20c. LOCATION — City or Town, State <b>West Chester, PA</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kenneth B. Carg</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kenneth B. Carg</b>		22. NAME AND ADDRESS OF FACILITY <b>Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>	
28b. TIME OF INJURY <b>NA</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>NA</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>NA</b>	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NA</b>		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>G.S. Prabhu M.D.</b> <b>DME</b>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 19th 97</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G.S. Prabhu M.D. 1810 Belair Rd # 102 Fallston MD. 21047 410-879-6564</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 21 1997</b>				32. REGISTRAR'S SIGNATURE <b>Jodi D. Kessler</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23659

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>DORIS E.F. BUSH</b>				2. Date of Death Month Day Year <b>JULY 15, 1997</b>		3. Time of Death <b>3:35 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>				4b. City, Town, or Location of Death <b>ROCKVILLE</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>150-28-9882</b>		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>62</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan. 5, 1935</b>	
	9. Birthplace (State or Foreign Country) <b>OHIO</b>		10a. State <b>MD</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				10e. Street and Number <b>101 Watkins Mill Road, Apt. F</b>		10f. Zip Code <b>20879</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b> <b>1 yr.</b>	
	16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Data Processor</b>				16b. Kind of Business/Industry <b>O.B. Federal</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Lacey W. Faust</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Rachael M. Tinsley</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Dana J. Bush (Son)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 Watkins Mill Rd., #F., Gaithersburg, MD 20879</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Gate of Heaven Cem.</b>		20c. Location - City or Town, State <b>7/21/97 Silver Spring, MD</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850</b>			
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>Acute Renal Failure</b> Due to (or as a consequence of): <b>Septic Shock</b> Due to (or as a consequence of): <b>Atherosclerotic cardiovascular disease</b> Due to (or as a consequence of): <b>5 years</b>				Approximate Interval Between Onset and Death <b>3d</b> <b>3d</b> <b>5 years</b>			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury M</b> 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No			
	28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			
To Be Completed by Physician/Medical Examiner	28f. Location (Street and Number or Rural Route Number, City or Town, State)				29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
	29b. Signature and title of certifier <b>David Holden MD</b>				29c. License number <b>047791</b>		29d. Date signed (Month, Day, Year) <b>July 22, 1997</b>	
State Registrar	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David A Holden 809 Veirs Mill, Rockville, MD 20851</b>				31. Date filed (Month, Day, Year) <b>JUL 22 1997</b>			
	32. Registrar's Signature <i>[Signature]</i>							



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23660

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAURENCE CHARLES BROWN

2. Date of Death

Month Day Year  
JULY 23, 1997

3. Time of Death

3:18 PM

4a. Facility Name (If not institution, give street and number)

4743 BRADLEY BOULEVARD

4b. City, Town, or Location of Death

CHEVY CHASE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

578-12-7270

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Sept 7, 1913

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

4743 Bradley Boulevard

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Department of the Navy

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

William P. Brown

18. Mother's Name (First, Middle, Maiden Surname)

Alice R. Mangan

19a. Informant's Name/Relationship (Type, Print)

Michael Anestos, Attorney

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11300 Rockville Pike, #1009, Rockville, MD 20852

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 30, 1997

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home  
2222 Wisconsin Avenue, N.W.  
Washington, DC 20007

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Artherosclerotic Heart Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

years

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration Pneumonia

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D33357

29d. Date signed (Month, Day, Year)

7/23/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Lee Jonathan Musher mrs 5530 Wisconsin Ave Chevy Chase MD

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23661

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last) Mildred M. Brooks				2. Date of Death Month Day Year July 21, 1997		3. Time of Death 3:00 PM	
4a. Facility Name (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL				4b. City, Town, or Location of Death ROCKVILLE		4c. County of Death MONTGOMERY	
5. Social Security Number 579-07-9762		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) 75 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) Sept. 16, 1921	
9. Birthplace (State or Foreign Country) Kansas							
10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Gaithersburg		10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No	
10e. Street and Number 201 Russell Avenue				10f. Zip Code 20877		10g. Citizen of What Country? United States	
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Secretary		16b. Kind of Business/Industry Federal Government			
17. Father's Name (First, Middle, Last) Stanley D. Bradshaw				18. Mother's Name (First, Middle, Maiden Surname) Goldie P. Davis			
19a. Informant's Name/Relationship (Type, Print) Bonnie J. Gaffney / daughter				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 743 Bywater Road, Gibson Island, Maryland 21056			
20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Memorial Park		20c. Location - City or Town, State Rockville, Maryland		20d. Date July 24, 1997	
21. Signature of Funeral Service Licensee Barbara J. McMullen				22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805			
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Acute Myocardial Infarction Due to (or as a consequence of): Minutes b. Chronic Renal Failure Due to (or as a consequence of): Yes c. Diabetes Mellitus Due to (or as a consequence of): Yes d. Hypertension Due to (or as a consequence of): Yes Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown							
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No							
25. Was case referred to medical examiner? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No							
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
28d. Describe how injury occurred				28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)			
28f. Location (Street and Number or Rural Route Number, City or Town, State)							
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. Signature and title of certifier William Dooley				29c. License number D 33261		29d. Date signed (Month, Day, Year) July 21, 1997	
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) William Dooley, M.D. 31 West Kirke Street, Chevy Chase, Maryland 20815							
31. Date filed (Month, Day, Year) JUL 25 1997				32. Registrar's Signature Julia Davidson-Randall			

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23662

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CLARENCE STERLING BRITT</b>				2. Date of Death Month <b>July</b> Day <b>16</b> Year <b>1997</b>		3. Time of Death <b>6:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>WILSON HEALTH CARE CENTER</b>				4b. City, Town, or Location of Death <b>GAITHERSBURG</b>		4c. County of Death <b>MONTGOMERY</b>	
Funeral Director	5. Social Security Number <b>383-26-9025</b>		8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>83</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	6. Date of Birth (Month, Day, Year) <b>July 4, 1914</b>	9. Birthplace (State or Foreign Country) <b>Texas</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Montgomery</b>		10c. City, Town or Location <b>Gaithersburg</b>		10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	
	10e. Street and Number <b>401 Russell Avenue, #404</b>				10f. Zip Code <b>20877</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>white</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Scientist</b>		16b. Kind of Business/Industry <b>U.S. Government &amp; University of MD</b>			
	17. Father's Name (First, Middle, Last) <b>Clarence Orlean Britt</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Viola Gardner</b>			
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Margaret S. Britt, Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>401 Russell Avenue, #404 Gaithersburg, MD 20877</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Cranford U. M. Church Cem.</b>		Data <b>7/21 1997</b>		20c. Location - City or Town, State <b>Lorton, Virginia</b>	
	21. Signature of Funeral Service Licensee <i>[Signature]</i>				22. Name and Address of Facility <b>DeVol Funeral Home 10 East Deer Park Dr., Gaithersburg, MD 20877</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Clear cell renal cancer</b>							Approximate Interval Between Onset and Death <b>years</b>
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic heart disease</b> <b>Congestive heart failure</b> <b>Atrial fibrillation</b>							23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier <b>Byrl D. Johnson, M.D.</b>		29c. License number <b>D-19042</b>		29d. Date signed (Month, Day, Year) <b>July 16, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>BYRL D. JOHNSON M.D. 911 Russell Avenue Gaithersburg, Maryland 20879</b>								
31. Date filed (Month, Day, Year) <b>JUL 21 1997</b>		32. Registrar's Signature <i>[Signature]</i>						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

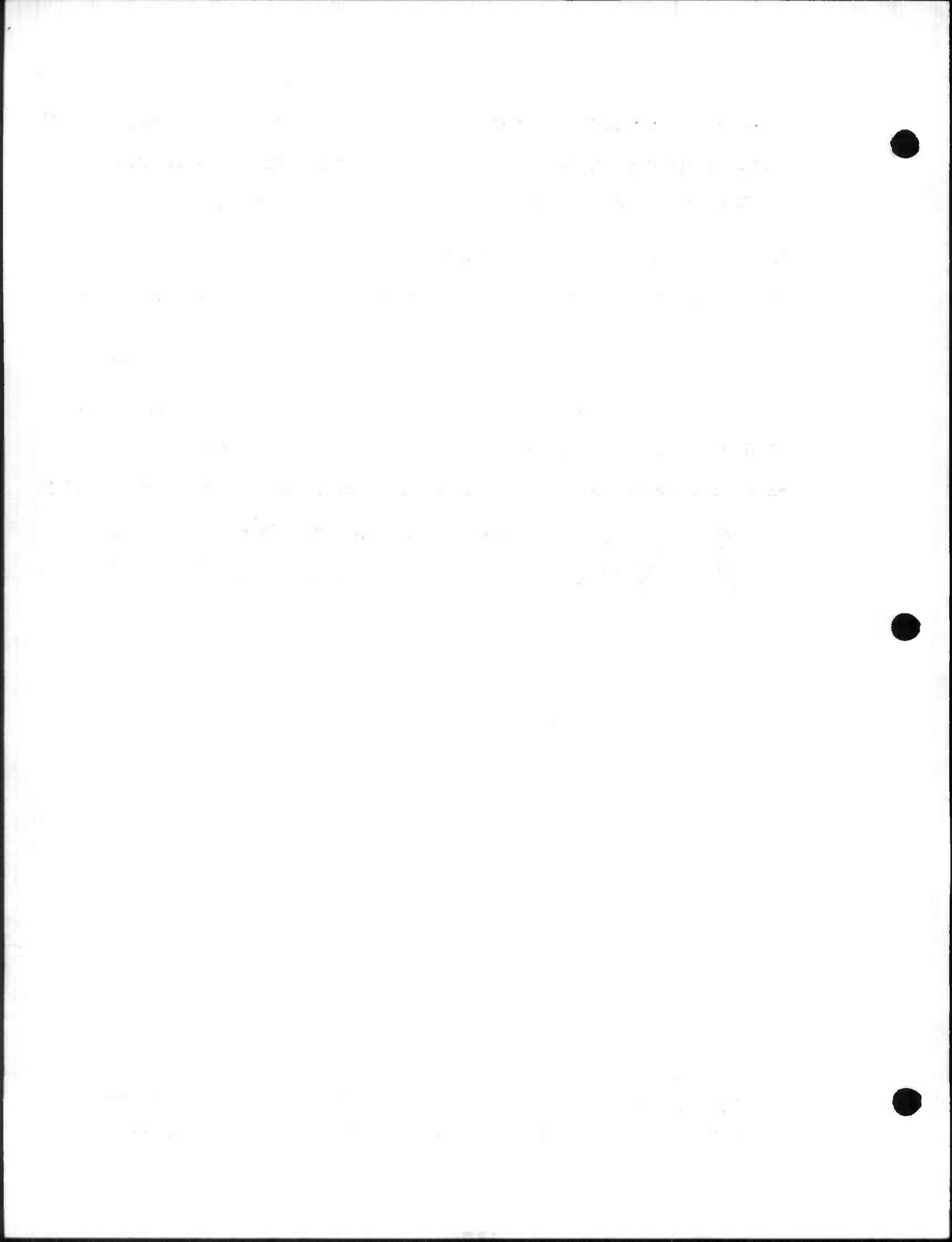
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23663

Amend #10e, 7/30/97, BMW, Montg. Co

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

EDITH MEAD BRIGGS

2. Date of Death

Month Day Year  
July 19, 1997

3. Time of Death

7:30pm

4a. Facility Name (If not institution, give street and number)

Wilson Health Care Center

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

5. Social Security Number

089-12-5090

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 21, 1916

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

403 Russell Avenue #701

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nutritionist / Dietician

16b. Kind of Business/Industry

General Foods

17. Father's Name (First, Middle, Last)

Frederick Briggs

18. Mother's Name (First, Middle, Maiden Surname)

Florence Hilcken

19a. Informant's Name/Relationship (Type, Print)

Carolyn Mohler (Cousin)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1550 Clay Hammond Road, Prince Frederick, MD 20678

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

7/20/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Michael D. Gibbons

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 2087723a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Cerebrovascular Accident - stroke

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

day

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Cerebrovascular Accident

Due to (or as a consequence of):

year

c. Hypertension

Due to (or as a consequence of):

year

d. Death

year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atherosclerosis of Heart

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Douglas R. Shuaker, MD

29c. License number

27301

29d. Date signed (Month, Day, Year)

July 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DOUGLAS R. SHUAKER, MD

615 W. MONTGOMERY AVE  
ROCKVILLE MD 20850

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23664

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucy Ann Bowman

2. Date of Death

Month Day Year  
July 18, 1997

3. Time of Death

10:00 AM

4a. Facility Name (If not institution, give street and number)

9511 Garwood Street

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-05-6136

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
Dec. 26, 1913

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9511 Garwood Street

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

John William Orrison

18. Mother's Name (First, Middle, Maiden Surname)

Judith May Grimes

19a. Informant's Name/Relationship (Type, Print)

John F. Bowman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12308 Fountain Drive Clarksburg, Maryland 20871

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hillsboro Cemetery

Date

7/21/97

20c. Location - City or Town, State

Hillsboro, Virginia

21. Signature of Funeral Service Licensee

Tracy A. Stover

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.  
500 University Blvd., W., Silver Spring, MD 2090123a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Acute Myocardial Infarction

Approximate  
Interval Between  
Onset and Death

10 Months

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

John Tauber

29c. License number

D 08546

29d. Date signed (Month, Day, Year)

July 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauber, M.D. 8218 Wisconsin Avenue #318 Bethesda, Maryland 20814-3107

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23665

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Margaret H. Billings				2. Date of Death Month Day Year JULY 23, 1997		3. Time of Death 12:15 AM							
	4a. Facility Name (If not Institution, give street and number) Manor Care - Wheaton				4b. City, Town, or Location of Death Silver Spring		4c. County of Death Montgomery							
Funeral Director	5. Social Security Number 577-01-1884		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 80 Yrs.		8. Date of Birth (Month, Day, Year) Nov. 18, 1916							
	9. Birthplace (State or Foreign Country) Washington, D.C.		10a. State Maryland		10b. County Montgomery		10c. City, Town or Location Rockville							
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No									
	10e. Street and Number 13807 Parkland Drive				10f. Zip Code 20853		10g. Citizen of What Country? U.S.A.							
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White							
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Accounting		16b. Kind of Business/Industry Federal Government									
	17. Father's Name (First, Middle, Last) William I. Barnes				18. Mother's Name (First, Middle, Maiden Surname) Helen Boyer									
	19a. Informant's Name/Relationship (Type, Print) John R. Billings				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13807 Parkland Drive Rockville, Maryland 20853									
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory		Date 7/24/97		20c. Location - City or Town, State Alexandria, Virginia							
	21. Signature of Funeral Service Licensee 		22. Name and Address of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W., Silver Spring, MD 20901											
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
	<table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>a. <u>Cardiomyopathy</u></td> <td rowspan="4">Due to (or as a consequence of):</td> <td rowspan="4">Approximate Interval Between Onset and Death Few Years</td> </tr> <tr> <td>b. <u>Coronary Artery Disease</u></td> </tr> <tr> <td>c. _____</td> </tr> <tr> <td>d. _____</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	a. <u>Cardiomyopathy</u>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death Few Years	b. <u>Coronary Artery Disease</u>	c. _____
Immediate Cause (Final disease or condition resulting in death)	a. <u>Cardiomyopathy</u>	Due to (or as a consequence of):	Approximate Interval Between Onset and Death Few Years											
	b. <u>Coronary Artery Disease</u>													
	c. _____													
	d. _____													
Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.														
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown														
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No														
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No														
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)														
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined														
28a. Date of Injury (Month, Day, Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 28d. Describe how injury occurred 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)														
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.														
29b. Signature and title of certifier  29c. License number D 42518 29d. Date signed (Month, Day, Year) July 23, 1997														
30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Gul Chablani, M.D. 11119 Rockville Pike #316 Rockville, Maryland 20852														
31. Date filed (Month, Day, Year) JUL 24 1997 32. Registrar's Signature 														

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

10

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23666

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joann Cox Benson

2. Date of Death

Month Day Year  
July 22, 1997

3. Time of Death

3:15 PM

4a. Facility Name (If not institution, give street and number)

Manor Care Bethesda

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

254-50-3501

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 10, 1934

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10100 Bencross Drive

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 1/2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Veterinarian Office

17. Father's Name (First, Middle, Last)

Charles Lee Cox

18. Mother's Name (First, Middle, Maiden Surname)

Mary Rutherford

19a. Informant's Name/Relationship (Type, Print)

Albert Charles Benson/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10100 Bencross Drive, Potomac, Maryland 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

July 25, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Michael E. Higgins M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-350123a. Part I. Enter the disease, or complications, which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Anoxic Encephalopathy

Months

Due to (or as a consequence of):

b. Ventricular Fibrillation

Months

Due to (or as a consequence of):

c. Cardiomyopathy

Years

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Harris Kenner, M.D.

29c. License number

D06019

29d. Date signed (Month, Day, Year)

July 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Harris Kenner, M.D. 6410 Rockledge Drive, #410, Bethesda, Maryland 20817

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23667  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARGARET C. BELL

2. Date of Death

Month

Day

Year

7

19

97

3. Time of Death

1:35pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Friends Nursing Home

4b. City, Town, or Location of Death

Sandy Spring

4c. County of Death

Montgomery

5. Social Security Number

577-05-7682

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Feb. 3, 1908

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4128 Norbeck Road

10f. Zip Code

20853

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

US Postal Service

17. Father's Name (First, Middle, Last)

John Casey

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Heany

19a. Informant's Name/Relationship (Type, Print)

Anne Marschall

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4128 Norbeck Road, Rockville, MD 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

7/22/97

20c. Location - City or Town, State

Brentwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Urosepsis  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 weeks

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's Dementia

Pernicious Anemia

Nephrolithiasis.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D35045

29d. Date signed (Month, Day, Year)

July 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3416 Olandwood Court #200 OLNEY, MD 20832

Dr. PHILIP HENJUM

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23668

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Margaret Maxine Billings</b>				2. Date of Death Month <b>July</b> Day <b>16</b> Year <b>1997</b>		3. Time of Death <b>8:57pm</b>	
	4a. Facility Name (If not institution, give street and number) <b>12701 Livestock Road</b>				4b. City, Town, or Location of Death <b>Sykesville</b>		4c. County of Death <b>Howard</b>	
Funeral Director	5. Social Security Number <b>237-54-8553</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>60</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>June 20 1937</b>	
	9. Birthplace (State or Foreign Country) <b>NC</b>		10a. State <b>MD</b>		10b. County <b>Howard</b>		10c. City, Town or Location <b>Sykesville</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>12701 Livestock Road</b>		10f. Zip Code <b>21784</b>	
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>white</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>homemaker</b>				16b. Kind of Business/Industry <b>domestic</b>		17. Father's Name (First, Middle, Last) <b>Emmett M. Hines</b>	
To Be Completed by Physician/Medical Examiner	18. Mother's Name (First, Middle, Maiden Surname) <b>Ethel Faye Nelson</b>				19a. Informant's Name/Relationship (Type, Print) <b>Dean Billings (husband)</b>		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12701 Livestock Rd. Sykesville, Md. 21784</b>	
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Pleasant Grove Cemetery</b>		20c. Location - City or Town, State <b>7-21-97 Independence, Va.</b>	
To Be Completed by Physician/Medical Examiner	21. Signature of Funeral Service Licensee <b>Brian R. Hay</b>				22. Name and Address of Facility <b>Haight Funeral Home &amp; Chapel P.O. Box 195 Sykesville, Md. 21784</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Respiratory Failure</b> Due to (or as a consequence of): <b>b. Chronic Progressive M.S.</b> Due to (or as a consequence of): <b>c.</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death <b>36 hours</b>			
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Urinary Infection</b>				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>28b. Time of Injury</b> <b>28c. Injury at Work?</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <b>28d. Describe how injury occurred</b> <b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b> <b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b>			
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>[Signature]</b>			
	29c. License number <b>522076</b>				29d. Date signed (Month, Day, Year) <b>7-17-97</b>			
To Be Completed by Physician/Medical Examiner	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Lawrence I. Silverberg, P.O. Box 257, W. Friendship, MD 21794</b>				31. Date filed (Month, Day, Year) <b>JUL 23 1997</b>			
	32. Registrar's Signature <b>[Signature]</b>				33. Registrar's Name <b>[Name]</b>			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23669

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kerry Beckham

2. Date of Death

7 18 97

3. Time of Death

3:00 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-42-4523

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 26, 1944

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

3110 River Bend Court G 101

10f. Zip Code

20724

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1968-74

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Offset Preparation Specialist

16b. Kind of Business/Industry

Printing

17. Father's Name (First, Middle, Last)

John S. Beckham

18. Mother's Name (First, Middle, Maiden Surname)

Shirley M. Kellam

19a. Informant's Name/Relationship (Type, Print)

Kenneth Brian Beckham

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7630 Nancy Drive, Elkridge, MD 21227

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

George Washington Cemetery

Date

7/23/97

20c. Location - City or Town, State

Adelphi, MD

21. Signature of Funeral Service Licensee

James E. O'Day

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Hypoxemia

Due to (or as a consequence of):

b. Cardiac Arrest

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

James E. O'Day

29c. License number

026057

29d. Date signed (Month, Day, Year)

7/19/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2012 Veirs Mill Road Wheaton MD 20906

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23670

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>WALLACE Bronson BAILEY</b>				2. Date of Death Month <b>July</b> Day <b>17</b> Year <b>1997</b>		3. Time of Death <b>8:45 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Washington Adventist Hospital</b>				4b. City, Town, or Location of Death <b>Takoma Park</b>		4c. County of Death <b>Montgomery</b>	
Funeral Director	5. Social Security Number <b>031-16-2574</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>72</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>Oct. 28, 1924</b>	9. Birthplace (State or Foreign Country) <b>Massachusetts</b>
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Beltsville</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10e. Street and Number <b>4701 Sellman Road</b>				10f. Zip Code <b>20705</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>1943-1946</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+) <b>4</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Electronic Engineer</b>		16b. Kind of Business/Industry <b>U.S. Government</b>		
17. Father's Name (First, Middle, Last) <b>Bertrand Wallace Bailey</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Hilda Poore</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Irene C. Bailey (wife)</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>same as #10</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Parklawn Cemetery</b>		20c. Location - City or Town, State <b>7/21/1997 Rockville, Maryland</b>		
21. Signature of Funeral Service Licensee <b>Donald V. Borgwardt</b>				22. Name and Address of Facility <b>Donald V. Borgwardt Funeral Home, P.A. 4400 Powder Mill Rd. Beltsville, Maryland 20705</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) a. <b>Acute myocardial infarction</b> Due to (or as a consequence of): b. <b>Coronary Heart Disease</b> Due to (or as a consequence of): c. <b>Arteriosclerosis</b> Due to (or as a consequence of): d.  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								Approximate Interval Between Onset and Death <b>11 Hours</b>
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No								24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
29b. Signature and title of certifier <b>Dr. H. S. Chaudhry MD</b>				29c. License number <b>14364</b>		29d. Date signed (Month, Day, Year) <b>7-18-97</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>M. H. Chaudhry MD 7610 Carroll Ave #300 Takoma Park, Md, 20912</b>								
31. Date filed (Month, Day, Year) <b>JUL 22 1997</b>				32. Registrar's Signature <b>John Davidson-Randall</b>				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

25

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23671

Items: 27, 28a-f per MEO G-751 9/26/97 dh

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Maria Teresa Boone</b>				2. Date of Death Month <b>July</b> Day <b>22</b> Year <b>1997</b>		3. Time of Death <b>9:37AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Physicians Memorial Hospital</b>				4b. City, Town, or Location of Death <b>La Plata</b>		4c. County of Death <b>Charles</b>	
Funeral Director	5. Social Security Number <b>577-90-0244</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>63</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Jan 25 1934</b>	
	9. Birthplace (State or Foreign Country) <b>Italy</b>		10a. State <b>MD</b>		10b. County <b>Charles</b>		10c. City, Town or Location <b>LaPlata</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				10e. Street and Number <b>7310 Greenland Pl.</b>		10f. Zip Code <b>20646</b>	
	10g. Citizen of What Country? <b>U.S.A.</b>				11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Linguist &amp; Translator</b>				16b. Kind of Business/Industry <b>Banking</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Alexandre Iordanow</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Phyllis MacLaurin Iordanow</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Raymond McGovern/P.R.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6204 North 12th St. Arlington, VA 22205</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Sacred Heart Cem. 7/26/97 LaPlata, MD</b>			
	21. Signature of Funeral Service Licensee <b>David C. Echols</b>				22. Name and Address of Facility <b>AREHART-ECHOLS FUNERAL HOME, INC. MO0945 P.O. Box 567 LaPlata, MD 20646</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Metabolic Encephalopathy</b> Due to (or as a consequence of): <b>b. Respirator Failure</b> Due to (or as a consequence of): <b>c. Foreign body in Trachea</b> Due to (or as a consequence of): <b>d.</b>				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>July 20, 1997</b>			
	28b. Time of Injury <b>6:00</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
To Be Completed by Physician/Medical Examiner	28d. Describe how injury occurred <b>choked on bolus of food</b>				28e. Location (Street and Number or Rural Route Number, City or Town, State) <b>7310 Greenland Place, LaPlata Md.</b>			
	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Michael Leatherwood, MD</b>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>D-21031</b>				29d. Date signed (Month, Day, Year) <b>9/22/97</b>			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Michael Leatherwood, MD 700 Old Line Center Suite 202 Waldorf, Maryland 20601</b>				31. Date filed (Month, Day, Year) <b>JUL 28 1997</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <b>Julia Davidson-Randall</b>				33. State Registrar <b>State Registrar</b>			
	34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020				35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23672

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) John Egon Bohle, Jr.			2. Date of Death Month Day Year June 29 1997		3. Time of Death 1:17 AM.		
	4a. Facility Name (If not institution, give street and number) St. Mary's Hospital			4b. City, Town, or Location of Death Leonardtwn		4c. County of Death St. Mary's		
Funeral Director	5. Social Security Number 213-36-9673		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 58 Yrs.		8. Date of Birth (Month, Day, Year) Nov 15, 1938	
	9. Birthplace (State or Foreign Country) Maryland		10a. State Maryland		10b. County St. Mary's		10c. City, Town or Location Mechanicsville	
To Be Completed by Funeral Director	10d. Inside City Limits 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		10e. Street and Number 27475 Three Notch Road		10f. Zip Code 20659		10g. Citizen of What Country? U.S.A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1956-1960		13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
To Be Completed by Physician/Medical Examiner	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) College		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Computer Program Analyst		16b. Kind of Business/Industry U.S. Government		17. Father's Name (First, Middle, Last) John Egon Bohle	
	18. Mother's Name (First, Middle, Maiden Surname) Louise M. Buckler		19a. Informant's Name/Relationship (Type, Print) Patricia Ann Bohle/Spouse		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27475 Three Notch Rd., Mechanicsville, MD 20659		20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	
To Be Completed by Physician/Medical Examiner	20b. Place of Disposition (Name of cemetery, crematory or other place) Trinity Memorial Gardens		20c. Date 7/2/97		20d. Location - City or Town, State Waldorf, MD		21. Signature of Funeral Service Licensee Michael K. Gardiner	
	22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, Maryland 20650		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Carcinoma Lung with metastasis Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		Approximate Interval Between Onset and Death 2/97		23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown	
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
	27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year) 28b. Time of Injury M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		28d. Describe how injury occurred		28e. Location (Street and Number or Rural Route Number, City or Town, State)	
To Be Completed by Physician/Medical Examiner	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.		29b. Signature and title of certifier [Signature]		29c. License number D33470		29d. Date signed (Month, Day, Year) 6/30/97	
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BHASKER JHAVERI M.D. LEONARDTOWN, MD. 20650		31. Date filed (Month, Day, Year) JUL -4 1997		32. Registrar's Signature [Signature]			

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

JOHN E. BOHLE JR.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23673

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Josephine Kinney Beitzell</b>				2. Date of Death Month <b>July</b> Day <b>5</b> Year <b>1997</b>				3. Time of Death <b>8:50 a.m.</b>				
	4e. Facility Name (If not institution, give street and number) <b>St. Mary's Nursing Center</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>				4c. County of Death <b>St. Mary's</b>				
Funeral Director	5. Social Security Number <b>578-46-1035</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>88</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>August 29, 1908</b>		9. Birthplace (State or Foreign Country) <b>New York</b>				
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Abell</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
To Be Completed by Funeral Director	10e. Street and Number <b>21726 Gerard's Cove Road</b>				10f. Zip Code <b>20606</b>				10g. Citizen of What Country? <b>United States</b>				
	11. Marital Status <input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>White</b>				
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>				16b. Kind of Business/Industry <b>n/a</b>				
	17. Father's Name (First, Middle, Last) <b>Jay P. Kinney</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Minnie Olive</b>								
To Be Completed by Physician/Medical Examiner	19a. Informant's Name/Relationship (Type, Print) <b>Jean B. Quinnette, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2540 Massachusetts Avenue, N.W., Washington, D.C. 20008</b>								
	20a. Method of Disposition <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. Location - City or Town, State <b>7-6-1997 Alexandria, Virginia</b>								
	21. Signature of Funeral Director <b>Michael K. Blankenship</b> MD0852				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650-0279</b>								
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death) <b>a. Cardiopulmonary Failure</b> Due to (or as a consequence of): <b>b. Carcinomatosis</b> Due to (or as a consequence of): <b>c. Carcinoma of Breast</b> Due to (or as a consequence of): <b>d.</b>								Approximate Interval Between Onset and Death <b>hrs yr, yrs</b>				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown					
								24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <b>N.A.</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred			
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)									
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. License number <b>MD06419</b>				29d. Date signed (Month, Day, Year) <b>5 July 1997</b>					
29b. Signature and title of certifier <b>J. Patrick Jarboe, M.D.</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>J. Patrick Jarboe, M.D., 22650 Peabody Street, Medical Arts Building, Leonardtown, Maryland 20650-0306</b>									
31. Date filed (Month, Day, Year) <b>JUL -7 1997</b>				32. Registrar's Signature <b>John Andrew Rashell</b>									

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

TIMOTHY

State of Maryland / Department of Health and Mental Hygiene

97 23674

BEAVERS

AMENDED #23-28F, 7/17/97, DLB, ST. MARYS

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Timothy James Beavers

2. Date of Death

Month Day Year

JUNE 28 1997

3. Time of Death

4:41 P.M.

4a. Facility Name (If not institution, give street and number)

ST. MARYS HOSPITAL

4b. City, Town, or Location of Death

LEONARDTOWN

4c. County of Death

ST. MARYS

5. Social Security Number

553-35-5496

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

36

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

October 13, 1960

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

California

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23364 Black Oak Court

10f. Zip Code

20619

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Installer

16b. Kind of Business/Industry

Carpet Company

17. Father's Name (First, Middle, Last)

Scotty Andrew Beavers

18. Mother's Name (First, Middle, Maiden Surname)

Billie Brenda Hatchett

19a. Informant's Name/Relationship (Type, Print)

Brenda Marshall, Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23364 Black Oak Court, California, Maryland 20619

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7-1-1997

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Home Licensee

Michael K. Blankenship, MO0852

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, Maryland 20650-0279

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Alcohol and Narcotic Intoxication

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cocaine Use

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☒ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

6/28/97

28b. Time of Injury

3:46 PM

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

in parking lot

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Early Bird Restaurant  
Hollywood, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JUNE 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL -2 1997

32. Registrar's Signature

John Davidson-R...

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23675

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George Stewart

2. Date of Death  
Month Day Year

July 21, 1997

3. Time of Death

1230 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Long View Nursing Home

4b. City, Town, or Location of Death

Manchester

4c. County of Death

Carroll

5. Social Security Number

212-32-4125

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Nov. 3, 1904

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Carroll

10c. City, Town or Location

Manchester

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3332 Main Street

10f. Zip Code

21102

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

George A. Bell

18. Mother's Name (First, Middle, Maiden Summa)

Ida Virginia Catherine Harbaugh

19a. Informant's Name/Relationship (Type, Print)

R. Kyle Pritts Jr.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

412 Washington Rd., Westminster, MD 21157

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Kridler's Church Cemetery

Date

07/24/97

20c. Location - City or Town, State

Westminster, MD

21. Signature of Funeral Service Licensee

Katherine Pritts - Sweitzer

22. Name of Funeral Home &amp; Chapel

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Acute Renal Failure

Due to (or as a consequence of):

b.

Arteriosclerotic Heart Disease

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

3 days

4 yrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation - Peripheral

Vascular Disease - Recent Cerebral

Vascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. H. Foad MD

29c. License number

D02386

29d. Date signed (Month, Day, Year)

7/21/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W H Foad MD 3223 MAIN ST. MANCHESTER, MD. 21102

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Anderson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23676

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Sarah V. Brown				2. Date of Death Month 07 - Day 18 - Year 97				3. Time of Death 1:20 P.M.	
	4e. Facility Name (If not institution, give street and number) Corsica Hill Nursing Home				4b. City, Town, or Location of Death Centreville				4c. County of Death Queen Anne	
Funeral Director	5. Social Security Number 220-26-2895		6. Sex 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) 89 Yrs.		8. Date of Birth (Month, Day, Year) 11-28-1907		9. Birthplace (State or Foreign Country) Maryland	
	Usual Residence of Decedent				10a. State Maryland		10b. County Queen Anne		10c. City, Town or Location Grasonville	
To Be Completed by Funeral Director	10a. State Maryland				10b. County Queen Anne				10c. City, Town or Location Grasonville	
	10e. Street and Number P.O. Box 221				10f. Zip Code 21638				10g. Citizen of What Country? USA	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: Black	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 7th College (1-4 or 5+) College (1-4 or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Domestic				16b. Kind of Business/Industry Domestic	
	17. Father's Name (First, Middle, Last) Levi Bouldin				18. Mother's Name (First, Middle, Maiden Surname) Mary Copper					
	19e. Informant's Name/Relationship (Type, Print) Mazie Bouldin (Sister-in-law)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. box 221, Grasonville, Maryland 21638					
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) Robinson AME Church Cem.				20c. Location - City or Town, State 07/25/97 Grasonville, Maryland	
	21. Signature of Funeral Service Licensee Phyllis A. Prince				22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 21601					
	23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) COPD Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				Approximate Interval Between Onset and Death 4 yrs					
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Demerol				23b. Did tobacco use contribute to the cause of death? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown					
24e. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No						
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28e. Date of Injury (Month, Day, Year)				28b. Time of Injury M		
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No				28d. Describe how injury occurred				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier Phyllis A. Prince				29c. License number D32186		
29d. Date signed (Month, Day, Year) 7/25/97				30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Gay Spratz 2108 P. Omaha Ave. Chalk, MD 21619						
31. Date filed (Month, Day, Year) JUL 25 1997				32. Registrar's Signature Julia Davidson-Randall						

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23677

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BERNICE G. CLIFF

2. Date of Death

Month Day Year  
JULY 14, 1997

3. Time of Death

9:05 AM

4a. Facility Name (If not institution, give street and number)

4534 NATAHALA DR. CLINTON, MD

4b. City, Town, or Location of Death

CLINTON, MD

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

577 44 5629

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG 6, 1918

9. Birthplace (State or Foreign Country)

SOUTH CAROLINA

Usual Residence of Decedent

10a. State

MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

CLINTON, MD

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

4534 NATAHALA DR.

10f. Zip Code

20735

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

ENTREPRENEUR

16b. Kind of Business/Industry

STORE

17. Father's Name (First, Middle, Last)

LORENZO PORTEE

18. Mother's Name (First, Middle, Maiden Surname)

CARRIE SIMON

19a. Informant's Name/Relationship (Type, Print)

VINCENT BLACKSHEAR (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4534 NATAHALA DR. CLINTON, MD

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

ARLINGTON NATIONAL

Date

JULY 18, 1997

20c. Location - City or Town, State

ARLINGTON, VA.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RALPH WILLIAMS FUNERAL SVC

517 11th STREET S.E.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Pancreatic Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

036-045379

29d. Date signed (Month, Day, Year)

7-21-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Hematology-Oncology/SGMO, 89th/1700S, Andrews AFB, MD 20762-6600

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23678

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Fred Curvington</b>				2. Date of Death Month <b>July</b> Day <b>18</b> Year <b>1997</b>		3. Time of Death <b>11:30 PM</b>	
	4a. Facility Name (If not institution, give street and number) <b>Prince George's Hospital</b>				4b. City, Town, or Location of Death <b>Cheverly</b>		4c. County of Death <b>Prince George's</b>	
Funeral Director	5. Social Security Number <b>210-22-0847</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>67</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>05-30-30</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>	
To Be Completed by Funeral Director	10c. City, Town or Location <b>Landover</b>				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	10e. Street and Number <b>7605 Ingrid Place</b>				10f. Zip Code <b>20785</b>		10g. Citizen of What Country? <b>USA</b>	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever In U.S. Armed Forces? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Presser</b>		16b. Kind of Business/Industry <b>Private</b>			
	17. Father's Name (First, Middle, Last) <b>Louis Hudson Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Louise Chandler</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Fred Curvington/Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7605 Ingrid Place, Landover, Maryland 20785</b>			
	20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Chesapeake Crematory</b>		Date <b>7/22/97</b>		20c. Location - City or Town, State <b>Beltsville, MD</b>	
	21. Signature of Funeral Service Licensee <b>Nancy A. Perentis</b>				22. Name and Address of Facility <b>J.B. Jenkins Funeral Home 7474 Landover Road, Landover, Maryland 20785</b>			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) <b>a. Arteriosclerotic Cardiovascular Disease</b> Due to (or as a consequence of): <b>years</b> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last <b>b. _____</b> Due to (or as a consequence of): <b>c. _____</b> Due to (or as a consequence of): <b>d. _____</b>							
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, Respiratory failure, Quinaprilin</b>							
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				
27. Manner of Death 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year) <b>N/A</b>		28b. Time of Injury <b>M</b>		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.				29b. Signature and title of certifier <b>Phillip Lubben</b>		29c. License number <b>001852</b>		
29d. Date signed (Month, Day, Year) <b>JULY 19 1997</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>Paul A. DeBee, MD 4203 Queensbury Rd Hyattsville MD 20785</b>								
31. Date filed (Month, Day, Year) <b>JUL 22 1997</b>				32. Registrar's Signature <b>John Andrew Randall</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23679

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>John E. Cummings</b>				2. Date of Death Month Day Year <b>July 21, 1997</b>		3. Time of Death <b>8:05 P.M.</b>																																					
	4a. Facility Name (If not institution, give street and number) <b>2401 Afton St.</b>				4b. City, Town, or Location of Death <b>Hillcrest Heights</b>		4c. County of Death <b>Prince George's</b>																																					
Funeral Director	5. Social Security Number <b>578-01-5512</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>79</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>Aug. 2, 1917</b>																																					
	9. Birthplace (State or Foreign Country) <b>Lick Ann, Va.</b>																																											
To Be Completed by Funeral Director	Usual Residence of Decedent				10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No																																							
	10a. State <b>Maryland</b>		10b. County <b>Prince George's</b>		10c. City, Town or Location <b>Hillcrest Heights</b>																																							
	10e. Street and Number <b>2401 Afton St.</b>				10f. Zip Code <b>20748</b>		10g. Citizen of What Country? <b>USA</b>																																					
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: <b>WWII</b>		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>																																					
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Manager</b>		16b. Kind of Business/Industry <b>Tire Store</b>																																							
	17. Father's Name (First, Middle, Last) <b>Samuel Cummings</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Martha Wright</b>																																							
	19a. Informant's Name/Relationship (Type, Print) <b>Bessie W. Cummings/Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as item 10</b>																																							
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Maryland Veteran's Cemetery</b>		Date <b>7/25/97</b>		20c. Location - City or Town, State <b>Cheltenham, Md.</b>																																					
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>George P. Kalas Funeral Home</b> <b>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>																																							
	23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																											
<table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="7">e. <b>Multiple Myeloma</b></td> </tr> <tr> <td colspan="7">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="7">b. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">c. Due to (or as a consequence of):</td> </tr> <tr> <td colspan="7">d. Due to (or as a consequence of):</td> </tr> </table>								Immediate Cause (Final disease or condition resulting in death)	e. <b>Multiple Myeloma</b>							Due to (or as a consequence of):							Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):							c. Due to (or as a consequence of):							d. Due to (or as a consequence of):						
Immediate Cause (Final disease or condition resulting in death)	e. <b>Multiple Myeloma</b>																																											
	Due to (or as a consequence of):																																											
	Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence of):																																										
		c. Due to (or as a consequence of):																																										
d. Due to (or as a consequence of):																																												
Approximate Interval Between Onset and Death <b>2 1/2 years</b>																																												
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																												
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown																																												
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																												
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																												
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No																																												
26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																																												
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined																																												
28a. Date of Injury (Month, Day, Year)																																												
28b. Time of Injury <b>M</b>																																												
28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No																																												
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28f. Location (Street and Number or Rural Route Number, City or Town, State)																																												
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.																																												
29b. Signature and title of certifier: 																																												
29c. License number <b>D20352</b>																																												
29d. Date signed (Month, Day, Year) <b>7/23/97</b>																																												
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>HARRY K 722 8920 WOOD RD CLINTON MD</b>																																												
31. Date filed (Month, Day, Year) <b>JUL 23 1997</b>																																												
32. Registrar's Signature 																																												

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

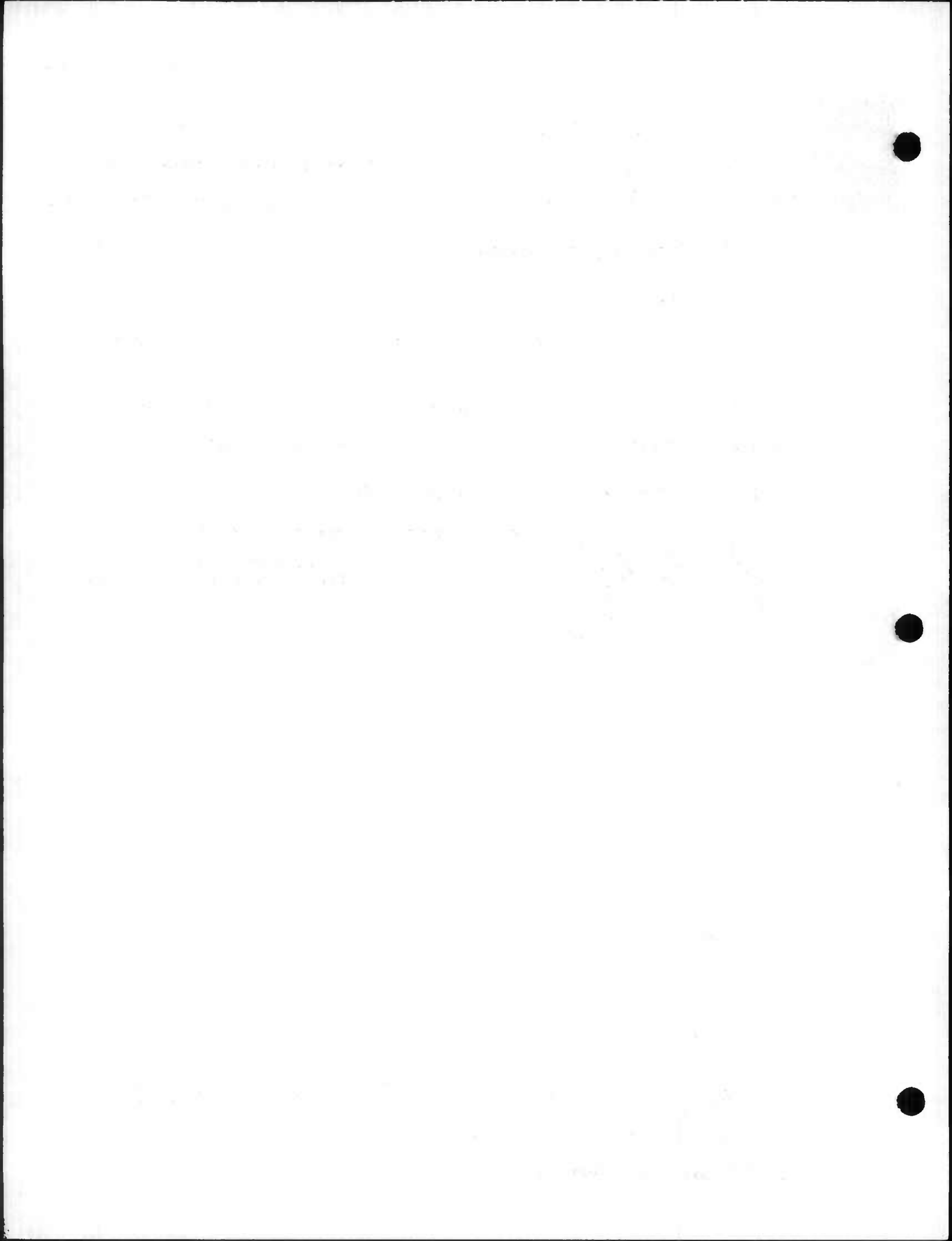
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23680

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HERBERT

2. Date of Death

Month Day Year

JULY 17 97

3. Time of Death

1428PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital 8600 Old Georgetown Rd

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

249-22-2478

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 18 1916

9. Birthplace (State or Foreign Country)

Carolina Sumter South

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5721 Grosvenor Lane

10f. Zip Code

20814

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Mover

16b. Kind of Business/Industry

Smith Transfer &amp;

Storage Company

17. Father's Name (First, Middle, Last)

Elmore Colclough

18. Mother's Name (First, Middle, Maiden Surname)

Alice Dargan

19a. Informant's Name/Relationship (Type, Print)

Herbert Colclough Jr. (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12603 Long Water Drive Mitchellville, MD 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland National Memorial 7/22/97 Laurel Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Latney's Funeral Home, Inc.

22. Name and Address of Facility

3831 Georgia Ave, NW Wash, DC 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

ACUTE

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D07094

29d. Date signed (Month, Day, Year)

JULY 17 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCIS C MAYB 1215 FERNWOOD RD BETHESDA MD 20814

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

John Anderson-Rodell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23681

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) James S. Culp				2. Date of Death Month Day Year July 18 1997		3. Time of Death 12:05 PM	
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center				4b. City, Town, or Location of Death Annapolis		4c. County of Death Anne Arundel	
Funeral Director	5. Social Security Number 578-46-5394		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) 61 Yrs.		8. Date of Birth (Month, Day, Year) Oct. 29, 1935	
	9. Birthplace (State or Foreign Country) North Carolina		10a. State MD		10b. County Montgomery		10c. City, Town or Location Potomac	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		10e. Street and Number 8201 Postoak Road		10f. Zip Code 20854		10g. Citizen of What Country? U. S. A.	
	11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1958-1962		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Vice President		16b. Kind of Business/Industry Utility Company			
	17. Father's Name (First, Middle, Last) James T. Culp				18. Mother's Name (First, Middle, Maiden Surname) Evelyn Stratford			
	19a. Informant's Name/Relationship (Type, Print) Nancy C. Culp - Wife				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8201 Postoak Road Potomac, MD 20854			
	20a. Method of Disposition 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) Parklawn Cemetery		20c. Location - City or Town, State Rockville, Maryland		20d. Date 7/23/97	
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility Joseph Gawler's Sons 5130 Wisconsin Ave. NW Washington, D. C. 20016			
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <u>Cardiac Arrest - Acute Anterior infarction</u> Due to (or as a consequence of): b. <u>Coronary Artery Disease</u> Due to (or as a consequence of): c. <u>Ischemic Cardiomyopathy</u> Due to (or as a consequence of): d. <u>Sick Sinus Syndrome</u>							
	23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown							
	24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No							
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Pacemaker</u> <u>Paroxysmal Atrial Fibrillation</u> <u>Obesity</u>							
	25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
	27. Manner of Death 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No	
	28d. Describe how injury occurred		28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
State Registrar	29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
	29b. Signature and title of certifier MD		29c. License number D32654		29d. Date signed (Month, Day, Year) July 18, 1997			
	30. Name and address of person who completed cause of death (Item 23e) (Type, Print) John Serlemitsos 1509 Ritchie Highway, Arnold, MD 21012							
31. Date filed (Month, Day, Year) JUL 21 1997		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23682

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Germaine St. Onge Corbett

2. Date of Death

Month  
JulyDay  
21Year  
1997

3. Time of Death

12:05 PM

4a. Facility Name (If not institution, give street and number)

Shady Grove Adventist Hospital

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-52-1604

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

86 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month, Day, Year  
Sept. 5, 1910

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1515 Dinster Road #25

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Cleophas St. Onge

18. Mother's Name (First, Middle, Maiden Surname)

Aurora Bourassa

19a. Informant's Name/Relationship (Type, Print)

Ann Germaine Corbett

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11014 Madison Street, Kensington, MD 20895

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mount Olivet Cemetery

Date

7/24/97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

Stuart D. Gend

22. Name and Address of Facility

Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia / Sepsis

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. congestive heart failure

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hip Fracture

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☒ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)  
April 17 199728b. Time of  
Injury

11 AM

28c. Injury et  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Fall

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

at Hospital

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

Shady Grove Adventist Hosp

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

John Tauber MD

29c. License number

D08946

29d. Date signed (Month, Day, Year)

July 24 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John Tauber 8218 Wisconsin Ave Bethesda Md.

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

Julia Davidson-Rodella

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23683

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NELSON O. CHIPCHIN

2. Date of Death

Month

Day

Year

JULY 17

97

3. Time of Death

16:00P

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

123-05-7108

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

March 18, 1911

9. Birthplace (State or Foreign Country)

Russia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Bethesda

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6409 Hollins Drive

10f. Zip Code

20817

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates:

WWII

1942-

1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foreign Service Officer

16b. Kind of Business/Industry

United States

Information Agency

17. Father's Name (First, Middle, Last)

Oscar Chipchin

18. Mother's Name (First, Middle, Maiden Surname)

Anna Zinde

19a. Informant's Name/Relationship (Type, Print)

Marilyn W. Chipchin

Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6409 Hollins Drive, Bethesda, Maryland 20817

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory

Date

7-18-97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rapp Funeral Services, P.A.

933 Gist Avenue, Silver Spring, MD 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. MYOCARDIAL INFARCTION

ACUTE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BLADDER CANCER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DO7099

29d. Date signed (Month, Day, Year)

JULY 18 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS C MAYLE 1024 FERNWOOD RD BETHESDA MD 20817

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23684

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Jonathan H. Chang

2. Date of Death

Month July 17, 1997 Year

3. Time of Death

6:45 PM

4a. Facility Name (If not institution, give street and number)

Laurel Regional Hospital

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

577-44-2762

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

80 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Jan 1, 1917 Year

9. Birthplace (State or Foreign Country)

China

Usual Residence of Decedent

10a. State

Maryland Montgomery

10b. County

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

15107 Interlochen Dr, #208

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (13-16)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Economist

16b. Kind of Business/Industry

Department of Education

17. Father's Name (First, Middle, Last)

Unobtainable

18. Mother's Name (First, Middle, Maiden Surname)

Unobtainable

19a. Informant's Name/Relationship (Type, Print)

Anita Chang/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15107 Interlochen Dr, #208, Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cem.

Date

Jul 21 '97 Silver Spring, MD

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Alan J. Donnell

22. Name and Address of Facility

Hines-Rinaldi Funeral Home

11800 New Hampshire Ave, Silver Spring, MD 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Bilateral Pneumonia

Due to (or as a consequence of):

Metastatic Carcinoma to Liver and Brain

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

Taky Mourtzanakis

29c. License number

D08307

29d. Date signed (Month, Day, Year)

July 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Taky Mourtzanakis 3450 Fort Meade Rd, Laurel, MD 20724

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23685

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Cecelia Teresa Carta

2. Date of Death

Month Day Year  
July 17 1997

3. Time of Death

2050

4a. Facility Name (If not institution, give street and number)

618 Wayne Avenue

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

578-42-6822

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 30, 1907

9. Birthplace (State or Foreign Country)

Italy

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

618 Wayne Avenue

10f. Zip Code

20910

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Joseph DiBlasi

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Terranova

19a. Informant's Name/Relationship (Type, Print)

Joseph DiBlasi

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

618 Wayne Avenue, Silver Spring, MD 20910

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/21/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility  
Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Cerebral Vascular Occlusion

Days

Due to (or as a consequence of):

b. Arteriosclerotic Cerebral Vascular Disease

Years

Due to (or as a consequence of):

c. Hypertension

Years

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sacral Ulcer

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D08480

29d. Date signed (Month, Day, Year)

July 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jerry Snow, M.D., 4900 Massachusetts Ave., N.W., Washington, DC 20016

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

3



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23686**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MIGUEL A. CANGAS

2. Date of Death

Month Day Year

July 21 1997

3. Time of Death

7:35pm

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-70-4893

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Sept. 25, 1933

9. Birthplace (State or Foreign Country)

Cuba

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9125 Walden Road

10f. Zip Code

20901

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☒ Yes 2 ☐ No Specify: Cuban

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Vice President

16b. Kind of Business/Industry

Grocery Store

17. Father's Name (First, Middle, Last)

Ceferino Cangas

18. Mother's Name (First, Middle, Maiden Surname)

Maria S. Mareque

19a. Informant's Name/Relationship (Type, Print)

Esperanza A. Cangas

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9125 Walden Road, Silver Spring, MD 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/25/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Edward D. Grand

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE HEMORRHAGIC PANCREATITIS

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

72 HRS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ACUTE RENAL FAILURE

RESPIRATORY FAILURE

RHABDOMYOLYSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Ernesto Africano, M.D.

29c. License number

D-19400

29d. Date signed (Month, Day, Year)

7-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTO AFRICANO, M.D. 831 University Boulevard, East Silver Spring, Maryland 20903

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23687

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>FREDERICK COLE</b>				2. Date of Death Month <b>JULY</b> Day <b>23</b> Year <b>1997</b>				3. Time of Death <b>1015 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>CHURCH Home Hospital</b>				4b. City, Town, or Location of Death <b>Baltimore City</b>				4c. County of Death <b>NONE</b>			
Funeral Director	5. Social Security Number <b>214-12-7111</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F		7. Age (In yrs. last birthday) <b>77</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>March 20, 1920</b>		9. Birthplace (State or Foreign Country) <b>Florida</b>			
	Usual Residence of Decedent				10a. State <b>Maryland</b>		10b. County <b>NONE</b>		10c. City, Town or Location <b>Baltimore</b>			
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>401 East 25th St.</b>				10f. Zip Code <b>21218</b>			
	10g. Citizen of What Country? <b>USA</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. Was Decedent Ever In U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:			
	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>				15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>			
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Self Employed</b>				16b. Kind of Business/Industry <b>Farming</b>				17. Father's Name (First, Middle, Last) <b>Wilmer Jenkins</b>			
	18. Mother's Name (First, Middle, Maiden Surname) <b>Mary Cole</b>				19a. Informant's Name/Relationship (Type, Print) <b>Gloria F Cole, Daughter</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3813 Summer City Blvd, Chesapeake Beach MD 20732</b>			
	20a. Method of Disposition <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>St. Mary's Ch. July 29/97 Brynmarion MD</b>				20c. Location - City or Town, State			
	21. Signature of Funeral Service Licensee 				22. Name and Address of Facility <b>Adams Funeral Home, Aquasco MD 20608</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>METASTATIC CANCER OF PROSTATE</b>			
	23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown				24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined			
	28a. Date of Injury (Month, Day, Year)				28b. Time of Injury <b>M</b>				28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No			
28d. Describe how injury occurred				28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Physician /Medical Examiner	29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>A. R. Vazquez MD</b>				29c. License number <b>D17322</b>			
	29d. Date signed (Month, Day, Year) <b>JULY 23, 1997</b>				30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>A. R. VAZQUEZ MD, CHURCH HOSPITAL, BALT. MD.</b>				31. Date filed (Month, Day, Year) <b>JUL 28 1997</b>			
	32. Registrar's Signature <b>Julia Davidson-Randall</b>				33. State Registrar				34. State Registrar			

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23688

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>CHARLIE CANADA</b>				2. Date of Death Month <b>July</b> Day <b>18</b> Year <b>1997</b>		3. Time of Death <b>8:36 AM</b>	
	4a. Facility Name (If not institution, give street and number) <b>SOUTHERN MARYLAND HOSPITAL</b>				4b. City, Town, or Location of Death <b>CLINTON</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>240-62-9151</b>		6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	7. Age (In yrs. last birthday) <b>61</b> Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Year) <b>August 28, 1935</b>	9. Birthplace (State or Foreign Country) <b>North Carolina</b>
	Usual Residence of Decedent							
To Be Completed by Funeral Director	10a. State <b>Maryland</b>		10b. County <b>Prince Georges</b>		10c. City, Town or Location <b>Upper Marlboro</b>			10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
	10e. Street and Number <b>9522 Croon Rd</b>				10f. Zip Code <b>20772</b>		10g. Citizen of What Country? <b>U.S.A.</b>	
	11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>	
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Supervisor</b>		16b. Kind of Business/Industry <b>Prince Georges Bd of Education</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Clarence Canada</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sinnie Williams</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Peggy Canada, Wife</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9522 Croon Rd, Upper Marlboro MD 20772</b>			
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Myers Church Cem, July 23, 1997</b>		20c. Location - City or Town, State <b>Upper Marlboro MD</b>		21. Signature of Funeral Service Licensee 	
	22. Name and Address of Facility <b>Adams Funeral Home, Agawasco, Maryland 20607</b>				23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immadiata Cause (Final disease or condition resulting in death)  a. <b>ACUTE MYOCARDIAL INFARCTION</b> Due to (or as a consequence of): b. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> Due to (or as a consequence of): c. Due to (or as a consequence of): d.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input type="checkbox"/> No		
25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		26. Place of Death (Check only one) Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred
		28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)		
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. Signature and title of certifier 		29c. License number <b>D-18545</b>		29d. Date signed (Month, Day, Year) <b>JULY 18, 1997</b>		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>P. WISOTSKY MD 700 OLD LINE CENTER WILMINGTON, DE. 20602</b>								
31. Date filed (Month, Day, Year) <b>JUL 28 1997</b>		32. Registrar's Signature 						

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

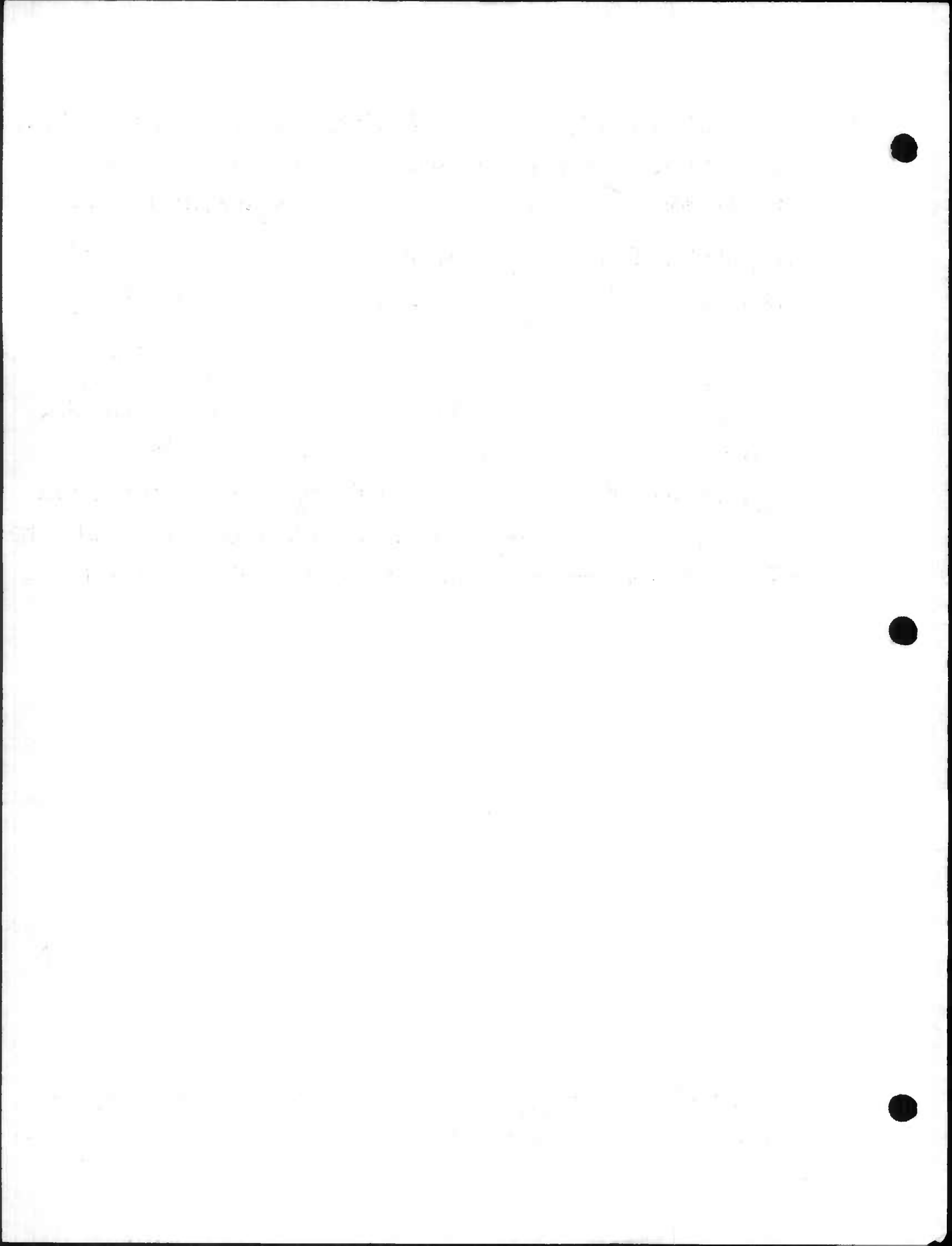
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23689

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Mary Florence Cropper</b>				2. Date of Death Month <b>June</b> Day <b>29</b> Year <b>1997</b>		3. Time of Death <b>12:10 PM.</b>	
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Hospital</b>				4b. City, Town, or Location of Death <b>Leonardtown</b>		4c. County of Death <b>St. Mary's</b>	
Funeral Director	5. Social Security Number <b>213-38-2421</b>	6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F	7. Age (In yrs. last birthday) <b>87</b> Yrs.	If Under 1 Year Months	If Under 24 Hrs. Hours	8. Date of Birth (Month, Day, Year) <b>May 12, 1910</b>	9. Birthplace (State or Foreign Country) <b>Maryland</b>	
	Usual Residence of Decedent							
10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>California</b>		10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
10a. Street and Number <b>23811 Kingston Creek Road</b>				10f. Zip Code <b>20619</b>		10g. Citizen of What Country? <b>United States</b>		
11. Marital Status <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: <b>White</b>		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>6</b>				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Principal</b>		16b. Kind of Business/Industry <b>Public School System</b>		
17. Father's Name (First, Middle, Last) <b>Joseph Linwood Davis</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Sarah Lewis</b>				
19a. Informant's Name/Relationship (Type, Print) <b>Reverend Fr. Dale T. Cropper, Jr., Son</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23760 Kingston Creek Road, California, MD 20619</b>				
20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>All Faith Episcopal</b>		20c. Location - City or Town, State <b>7/3/97 Huntersville, Maryland</b>		
21. Signature of Funeral Director <b>Edward W. Brinsfield, Jr. MO0052</b>				22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650</b>				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <div style="display: flex; justify-content: space-between;"> <div> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</p> </div> <div> <p><b>Cardiopulmonary Failure</b> Due to (or as a consequence of):</p> <p><b>Cardiac Arrhythmia</b> Due to (or as a consequence of):</p> <p><b>Hypertensive Cardiovascular DE</b> Due to (or as a consequence of):</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> <p><b>3 hrs</b></p> <p><b>3 hrs</b></p> <p><b>years</b></p> </div> </div>								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown		
						24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
						24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pandemic Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. Date of Injury (Month, Day, Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		
28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28d. Describe how injury occurred				
28f. Location (Street and Number or Rural Route Number, City or Town, State)								
29a. Certifier (Check only one) <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <b>J. Patrick Jarboe M.D.</b>		29c. License number <b>D 06419</b>		
29d. Date signed (Month, Day, Year) <b>6-30-97</b>								
30. Name and address of person who completed cause of death (Item 23e) (Type, Print) <b>J. PATRICK JARBOE M.D. LEONARDTOWN, MD. 20650</b>								
31. Date filed (Month, Day, Year) <b>JUL -2 1997</b>				32. Registrar's Signature <b>J. Patrick Jarboe M.D.</b>				

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

FLORENCE DAVIS CROPPER  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23690

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARTHUR W CROWNOVER

2. Date of Death

Month Day Year  
July 5 1997

3. Time of Death

1:00 AM

4a. Facility Name (If not institution, give street and number)

Charlotte Hall Veteran's Home

4b. City, Town, or Location of Death

Charlotte Hall

4c. County of Death

St. Mary

Funeral  
Director

5. Social Security Number

213-16-3386

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 3, 1918

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Edgewater

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

3434 Pike Ridge Rd.

10f. Zip Code

21037

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Diesel Engineman

16b. Kind of Business/Industry

Experimental Station

17. Father's Name (First, Middle, Last)

Arthur W. Crownover, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Louise Coveney

19a. Informant's Name/Relationship (Type, Print)

Helen Jocus/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3413 Hazelwood Rd., Edgewater, MD 21037

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory, or other place)

Newton Hamilton Memorial Cemetery

Date

7/9/97

20c. Location - City or Town, State

Newton Hamilton, PA

21. Signature of Funeral Service Licensee

Mary B. Rizzo

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, PA  
P.O. Box 270, Leonardtown, MD 20650

23a. Pert I. Enter the disease, or combination of diseases, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF RECTUM

Approximate Interval Between Onset and Death

MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

CORONARY ARTERY DISEASE

SUPRANUCLEAR PALSY

23b. Did tobacco use contribute to the cause of death?

☒ Yes ☐ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient

☐ ER/Outpatient

☐ DOA

Other:

☒ Nursing Home

☐ Residence

☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicidal ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician

☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Dr. Ashvinkumar J. Patel, M.D. Attending

29c. License number

D-44436

29d. Date signed (Month, Day, Year)

July 08 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHVINKUMAR J. PATEL, MD 603 POST OFFICE ROAD WALDORF MD 20602

31. Date filed (Month, Day, Year)

JUL - 9 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23691**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARION A CLENDENIN

2. Date of Death

Month Day Year  
July 10 1997

3. Time of Death

4:55 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

578-44-4882

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 17, 1907

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8401 Fox Run

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

George W. Ellis

18. Mother's Name (First, Middle, Maiden Surname)

Mary Magdalen Norris

19a. Informant's Name/Relationship (Type, Print)

Pattie E. Powers/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8401 Fox Run, Potomac, MD 20854

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart Cemetery

Date

7/12/97

20c. Location - City or Town, State

Bushwood, MD

21. Signature of Funeral Service Licensee

Michael K. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL INSUFFICIENCY

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Peter G. Hamner MD

29c. License number

D32033

29d. Date signed (Month, Day, Year)

7/10/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PETER G. HAMNER MD 5454 WISC. AVE CHERRY CHASE, MD 20815

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

J. A. Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23692

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GERALD

COHEN, JR.

2. Date of Death

Month Day Year  
JULY 17, 1997

3. Time of Death

2:40 PM

4a. Facility Name (If not institution, give street and number)

800 S. MORRIS ST.

4b. City, Town, or Location of Death

OXFORD

4c. County of Death

TALBOT

Funeral  
Director

5. Social Security Number

212-07-5810

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
SEPT. 17, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

TALBOT

10c. City, Town or Location

OXFORD

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

800 S. MORRIS ST.

10f. Zip Code

21654

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: KOREAN

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MILITARY PERSONNEL

16b. Kind of Business/Industry

MILITARY

17. Father's Name (First, Middle, Last)

GERALD COHEN, SR.

18. Mother's Name (First, Middle, Maiden Summa)

ELLEN LORETTA BYRNE

19a. Informant's Name/Relationship (Type, Print)

SALLY EVANS/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

BOX 574, OXFORD, MD 21654

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MD. ANATOMICAL BOARD

Data

7-18

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME  
200 S. HARRISON ST., EASTON, MD 21601

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hemorrhagic CVA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 wk

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Cerebrovascular Dz

Due to (or as a consequence of):

10 yr

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural5 ☐ Pending investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D42816

29d. Date signed (Month, Day, Year)

7/18/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RICHARD A. BURGOYNE, M.D., 607 DUTCHMAN'S LANE, EASTON, MD 21601

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23693

Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Frances Dorothy Capper</b>					2. Date of Death Month Day Year <b>July 28, 1997</b>		3. Time of Death <b>6:15 AM</b>			
	4a. Facility Name (If not institution, give street and number) <b>St. Mary's Nursing Center</b>					4b. City, Town, or Location of Death <b>Leonardtown</b>		4c. County of Death <b>St. Mary's</b>			
Funeral Director	5. Social Security Number <b>224-62-4127</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>83</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>February 14, 1914</b>		9. Birthplace (State or Foreign Country) <b>United Kingdom</b>		
	Usual Residence of Decedent					10a. State <b>Maryland</b>		10b. County <b>St. Mary's</b>		10c. City, Town or Location <b>Dameron</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					10e. Street and Number <b>P.O. Box 270</b>		10f. Zip Code <b>20628</b>		10g. Citizen of What Country? <b>United States</b>	
	11. Marital Status <input type="checkbox"/> Navar Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:			14. Race - American Indian, Black, White, etc. Specify: <b>White</b>			
	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)				16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Homemaker</b>			16b. Kind of Business/Industry <b>N/A</b>			
	17. Father's Name (First, Middle, Last) <b>Thomas Nisbet</b>					18. Mother's Name (First, Middle, Maiden Surname) <b>Unknown</b>					
	19a. Informant's Name/Relationship (Type, Print) <b>Daniel Capper, Step-son</b>					19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 270, Dameron, Maryland 20628</b>					
	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Trinity Episcopal Cemetery</b>			20c. Location - City or Town, State <b>St. Mary's City, Maryland</b>		20d. Date <b>7/31/97</b>		
	21. Signature of Funeral Service Licensee <b>Michael K. Blankenship</b>					22. Name and Address of Facility <b>Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, Maryland 20650</b>					
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Alzheimer's Disease</b> Due to (or as a consequence of):										
	23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.										
	23c. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown										
24a. Was an autopsy performed? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
24b. Were autopsy findings available prior to completion of cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No											
Medical Certification: To Be Completed by Physician/Medical Examiner	25. Was case referred to medical examiner? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No					28. Piece of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
	27. Manner of Death <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicida <input type="checkbox"/> Homicida <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury <b>M</b>		28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No		28d. Describe how injury occurred		
	29a. Certifier (Check only one) <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated.					29b. Signature and title of certifier <b>David Allen MD</b>					
	29c. License number <b>D25230</b>					29d. Date signed (Month, Day, Year) <b>7/30/97</b>					
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>David Allen MD 2050 Wildewood Ctr California MD 20619</b>										
State Registrar	31. Date filed (Month, Day, Year) <b>JUL 31 1997</b>					32. Registrar's Signature <b>John Anderson Randall</b>					

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23694

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) <b>Ann Gayle Davis</b>				2. Date of Death Month Day Year <b>JULY 17, 1997</b>		3. Time of Death <b>5:30AM</b>	
	4a. Facility Name (If not Institution, give street and number) <b>NAYLOR ROAD NEAR GOODHOPE ROAD</b>				4b. City, Town, or Location of Death <b>HILLCREST HEIGHTS</b>		4c. County of Death <b>PRINCE GEORGES</b>	
Funeral Director	5. Social Security Number <b>579-70-6657</b>		6. Sex <input type="checkbox"/> M <input checked="" type="checkbox"/> F		7. Age (In yrs. last birthday) <b>45</b> Yrs.		8. Date of Birth (Month, Day, Year) <b>5-30-1952</b>	
	9. Birthplace (State or Foreign Country) <b>Norfolk, VA</b>		10a. State <b>MD</b>		10b. County <b>Temple Hills</b>		10c. City, Town or Location <b>Temple Hills</b>	
To Be Completed by Funeral Director	10d. Inside City Limits <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				10e. Street and Number <b>3103 Good Hope Ave., #202</b>		10f. Zip Code <b>20748</b>	
	10g. Citizen of What Country? <b>U S A</b>				11. Marital Status <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If Yes, Give Year or Dates:	
To Be Completed by Physician/Medical Examiner	13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:				14. Race - American Indian, Black, White, etc. Specify: <b>Black</b>		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)	
	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) <b>Housewife</b>				16b. Kind of Business/Industry <b>Own Home</b>			
To Be Completed by Physician/Medical Examiner	17. Father's Name (First, Middle, Last) <b>Johnnie White, Sr.</b>				18. Mother's Name (First, Middle, Maiden Surname) <b>Elizabeth Washington</b>			
	19a. Informant's Name/Relationship (Type, Print) <b>Johnnie White, Jr.</b>				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1305 Orren St., NE Apt. # 4 / WDC 20002</b>			
To Be Completed by Physician/Medical Examiner	20a. Method of Disposition <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. Place of Disposition (Name of cemetery, crematory or other place) <b>Forest Hill Memorial</b>		20c. Location - City or Town, State <b>Clinton, MD</b>	
	21. Signature of Funeral Service Licensee <i>Shelly Bell</i>				22. Name and Address of Facility <b>Robert G. Mason F. H. 1661 Good Hope Rd., SE 20020</b>			
To Be Completed by Physician/Medical Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. <b>Multiple Injuries</b> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last				Approximate Interval Between Onset and Death			
	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				23b. Did tobacco use contribute to the cause of death? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown			
To Be Completed by Physician/Medical Examiner	24a. Was an autopsy performed? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				24b. Were autopsy findings available prior to completion of cause of death? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No			
	25. Was case referred to medical examiner? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No				26. Place of Death (Check only one) Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>ROADWAY</b>			
To Be Completed by Physician/Medical Examiner	27. Manner of Death <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. Date of Injury (Month, Day, Year) <b>7/17/97</b>		28b. Time of Injury <b>5:30 A</b> M	
	28c. Injury at Work? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No				28d. Describe how injury occurred <b>pedestrian struck by auto</b>			
To Be Completed by Physician/Medical Examiner	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) <b>street</b>				28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>Naylor Rd + Good Hope Intersection P.G. Co Md</b>			
	29a. Certifier (Check only one) <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. Signature and title of certifier <i>Dennis J. Chute</i>			
To Be Completed by Physician/Medical Examiner	29c. License number <b>O.C.M.E.</b>				29d. Date signed (Month, Day, Year) <b>JULY 17, 1997</b>			
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>				31. Date filed (Month, Day, Year) <b>JUL 22 1997</b>			
To Be Completed by Physician/Medical Examiner	32. Registrar's Signature <i>Johnnie White</i>				33. Registrar's Signature <i>Johnnie White</i>			
	34. Registrar's Signature <i>Johnnie White</i>				35. Registrar's Signature <i>Johnnie White</i>			

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23695

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Emmanuel J. DeMesme, Sr.

2. Date of Death

Month Day Year  
July 20 97

3. Time of Death

9:25 AM

4a. Facility Name (If not institution, give street and number)

Ft. Washington Hospital

4b. City, Town, or Location of Death

Ft. Washington

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

436-32-7298

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

70 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 10, 1927

9. Birthplace (State or Foreign Country)

Louisiana

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

914 Forest Drive South

10f. Zip Code

20745

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates: 1948-5113. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (13-16)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Chief of Assignment Branch Federal Government

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

Charles Paul DeMesme

18. Mother's Name (First, Middle, Maiden Surname)

Gweneth Maria Duncan

19a. Informant's Name/Relationship (Type, Print)

Lorraine A. DeMesme/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

914 Forest Dr., South, Oxon Hill, Md. 20745

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Resurrection Cemetery 7/25/97

Date

20c. Location - City or Town, State

Clinton, Maryland

21. Signature of Funeral Service Licensee

George P. Kalas

22. Name and Address of Facility

George P. Kalas Funeral Home  
6160 Oxon Hill Rd. Oxon Hill, Md. 2074523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Lung Cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

7 mos

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Kenneth Goldstein

29c. License number

D17211

29d. Date signed (Month, Day, Year)

July 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kenneth Goldstein, M.D. 2141 K St., N. W., #707, Washington, D. C.

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John A. ...

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23696

## Certificate of Death

Reg. No.

Physician /Medical Examiner	1. Decedent's Name (First, Middle, Last) Walter Reed DeForest				2. Date of Death Month Day Year July 17 1997		3. Time of Death 12:52p.m.	
	4a. Facility Name (If not institution, give street and number) 723 Clayton Street				4b. City, Town, or Location of Death Aberdeen		4c. County of Death Harford	
Funeral Director	5. Social Security Number 106-16-4510		6. Sex 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		7. Age (In yrs. last birthday) 79 Yrs.		8. Date of Birth (Month, Day, Year) April 6, 1918	
	9. Birthplace (State or Foreign Country) New York		10a. State Maryland		10b. County Harford		10c. City, Town or Location Aberdeen	
10d. Inside City Limits 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No		10e. Street and Number 723 Clayton Street		10f. Zip Code 21001		10g. Citizen of What Country? U.S.A.		
11. Marital Status 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: 1944-46		13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:		14. Race - American Indian, Black, White, etc. Specify: White		
15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Program Manager		16b. Kind of Business/Industry Civil Service				
17. Father's Name (First, Middle, Last) Walter Stanley DeForest				18. Mother's Name (First, Middle, Maiden Surname) Lizzie Hendershott				
19a. Informant's Name/Relationship (Type, Print) Mrs. Trudy J. DeForest (spouse)				19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 723 Clayton Street, Aberdeen, Maryland 21001				
20a. Method of Disposition 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. Place of Disposition (Name of cemetery, crematory or other place) R. A. Ferris & Co., Inc.		Date 7/18/97		20c. Location - City or Town, State West Chester, PA		
21. Signature of Funeral Service Licensee Kirsten Amy Unglesser				22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001-3399				
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. advanced dilated cardiomyopathy Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last								
23b. Did tobacco use contribute to the cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown								
24a. Was an autopsy performed? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No								
24b. Were autopsy findings available prior to completion of cause of death? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No								
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Lung Disease diabetes								
25. Was case referred to medical examiner? 1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No		26. Place of Death (Check only one) Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. Manner of Death 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. Date of Injury (Month, Day Year)		28b. Time of Injury M		28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No		
28d. Describe how injury occurred		28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one) 1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. Signature and title of certifier Hans J. Kim, MD				29c. License number 037364		29d. Date signed (Month, Day, Year) July 17, 1997		
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19 Walnut Lane, Aberdeen, Maryland								
31. Date filed (Month, Day, Year) JUL 21 1997				32. Registrar's Signature John H. Randall				

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200.

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301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400.

401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500.

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601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700.

701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800.

801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 841. 842. 843. 844. 845. 846. 847. 848. 849. 850. 851. 852. 853. 854. 855. 856. 857. 858. 859. 860. 861. 862. 863. 864. 865. 866. 867. 868. 869. 870. 871. 872. 873. 874. 875. 876. 877. 878. 879. 880. 881. 882. 883. 884. 885. 886. 887. 888. 889. 890. 891. 892. 893. 894. 895. 896. 897. 898. 899. 900.

901. 902. 903. 904. 905. 906. 907. 908. 909. 910. 911. 912. 913. 914. 915. 916. 917. 918. 919. 920. 921. 922. 923. 924. 925. 926. 927. 928. 929. 930. 931. 932. 933. 934. 935. 936. 937. 938. 939. 940. 941. 942. 943. 944. 945. 946. 947. 948. 949. 950. 951. 952. 953. 954. 955. 956. 957. 958. 959. 960. 961. 962. 963. 964. 965. 966. 967. 968. 969. 970. 971. 972. 973. 974. 975. 976. 977. 978. 979. 980. 981. 982. 983. 984. 985. 986. 987. 988. 989. 990. 991. 992. 993. 994. 995. 996. 997. 998. 999. 1000.

1001. 1002. 1003. 1004. 1005. 1006. 1007. 1008. 1009. 1010. 1011. 1012. 1013. 1014. 1015. 1016. 1017. 1018. 1019. 1020. 1021. 1022. 1023. 1024. 1025. 1026. 1027. 1028. 1029. 1030. 1031. 1032. 1033. 1034. 1035. 1036. 1037. 1038. 1039. 1040. 1041. 1042. 1043. 1044. 1045. 1046. 1047. 1048. 1049. 1050. 1051. 1052. 1053. 1054. 1055. 1056. 1057. 1058. 1059. 1060. 1061. 1062. 1063. 1064. 1065. 1066. 1067. 1068. 1069. 1070. 1071. 1072. 1073. 1074. 1075. 1076. 1077. 1078. 1079. 1080. 1081. 1082. 1083. 1084. 1085. 1086. 1087. 1088. 1089. 1090. 1091. 1092. 1093. 1094. 1095. 1096. 1097. 1098. 1099. 1100.

1101. 1102. 1103. 1104. 1105. 1106. 1107. 1108. 1109. 1110. 1111. 1112. 1113. 1114. 1115. 1116. 1117. 1118. 1119. 1120. 1121. 1122. 1123. 1124. 1125. 1126. 1127. 1128. 1129. 1130. 1131. 1132. 1133. 1134. 1135. 1136. 1137. 1138. 1139. 1140. 1141. 1142. 1143. 1144. 1145. 1146. 1147. 1148. 1149. 1150. 1151. 1152. 1153. 1154. 1155. 1156. 1157. 1158. 1159. 1160. 1161. 1162. 1163. 1164. 1165. 1166. 1167. 1168. 1169. 1170. 1171. 1172. 1173. 1174. 1175. 1176. 1177. 1178. 1179. 1180. 1181. 1182. 1183. 1184. 1185. 1186. 1187. 1188. 1189. 1190. 1191. 1192. 1193. 1194. 1195. 1196. 1197. 1198. 1199. 1200.

1201. 1202. 1203. 1204. 1205. 1206. 1207. 1208. 1209. 1210. 1211. 1212. 1213. 1214. 1215. 1216. 1217. 1218. 1219. 1220. 1221. 1222. 1223. 1224. 1225. 1226. 1227. 1228. 1229. 1230. 1231. 1232. 1233. 1234. 1235. 1236. 1237. 1238. 1239. 1240. 1241. 1242. 1243. 1244. 1245. 1246. 1247. 1248. 1249. 1250. 1251. 1252. 1253. 1254. 1255. 1256. 1257. 1258. 1259. 1260. 1261. 1262. 1263. 1264. 1265. 1266. 1267. 1268. 1269. 1270. 1271. 1272. 1273. 1274. 1275. 1276. 1277. 1278. 1279. 1280. 1281. 1282. 1283. 1284. 1285. 1286. 1287. 1288. 1289. 1290. 1291. 1292. 1293. 1294. 1295. 1296. 1297. 1298. 1299. 1300.



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State of Maryland / Department of Health and Mental Hygiene

97 23697

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Megerdich Derzookian

2. Date of Death

Month Day Year  
July 17 1997

3. Time of Death

7:55 A.M.

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

215-54-5743

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 4, 1913

9. Birthplace (State or Foreign Country)

Iran

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

26 Orchard Way North

10f. Zip Code

20854

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Accountant

16b. Kind of Business/Industry

Accounting

17. Father's Name (First, Middle, Last)

Arestakes Mardirossian-Derzookian

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Sosse Dombalagian - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3712 Clairton Drive Mitchellville, MD 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Cemetery

Date

7/21/97

20c. Location - City or Town, State

Rockville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Joseph Gawler's Sons

5130 Wisc. Ave. NW Washington, D. C. 20016

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Acute Myocardial Infarction

6 Hours

Due to (or as a consequence of):

b. Pulmonary Edema

6 Hours

Due to (or as a consequence of):

c. Chronic Obstructive Lung Disease

5 Years

Due to (or as a consequence of):

d. Osteomyelitis

3 Weeks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

End Stage Renal Disease

Hypertension

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 23091

29d. Date signed (Month, Day, Year)

July 17, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Nossuli A. Kaldun

4915 Auburn Ave. Bethesda, MD 20814

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

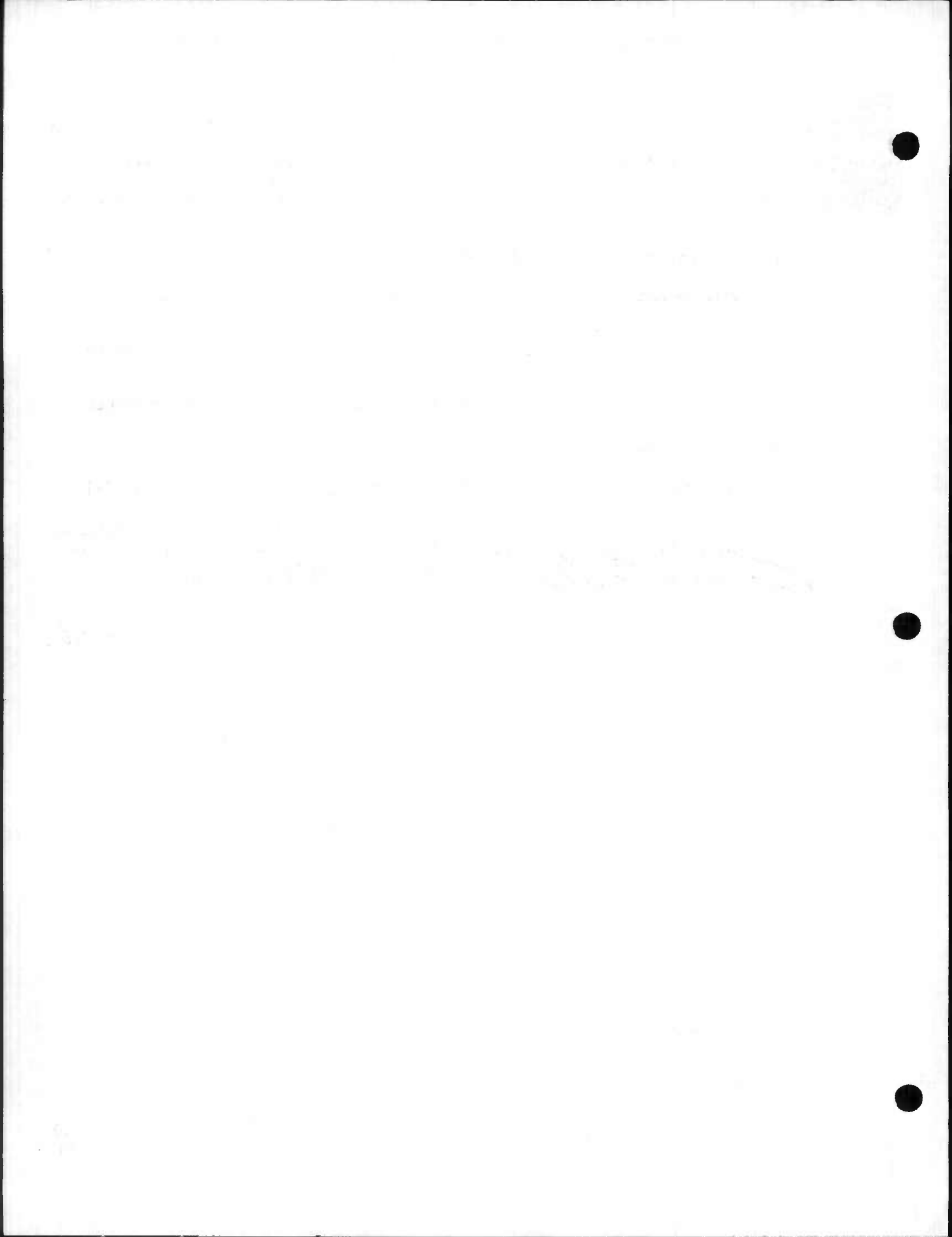
State of Maryland / Department of Health and Mental Hygiene

97 23698

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Anthony DeMattia, Sr.</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>9:40 p m</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>2801 Village Lane</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>064-01-7358</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 16, 1916</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Connecticut</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>2801 Village Lane</b>  |  | 10f. Zip Code<br><b>20906</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1940-1970</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Physician/Medical Examiner   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Colonel</b>   |  | 16b. Kind of Business/Industry<br><b>U. S. Army</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Raffaell DeMattia</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Caroline Mele</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Anthony DeMattia, Jr.</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5795 Alfran Drive, Mt. Airy, Maryland 21771</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |
| Physician<br>/Medical<br>Examiner   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National Cem.</b>   |  | 20c. Date<br><b>8/1/97</b>  |  | 20d. Location - City or Town, State<br><b>Arlington, Virginia</b>  |  | 21. Signature of Funeral Service Licensee<br>  |  |
|   | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home<br/>11800 New Hampshire Avenue<br/>Silver Spring, Maryland 20904</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Metastatic Carcinoma of Colon</b> |  | 23b. Approximate Interval Between Onset and Death<br><b>Months</b>   |  | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic lymphocytic leukemia<br/>Carcinoma of Prostate.</b>  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.<br>To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D21115</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/21/97</b>  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Lee R. Pennington, MD, 5602 Shields Drive, Bethesda, MD 20817</b>   |  |
| State Registrar   | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |  | 32. Registrar's Signature<br>  |  | 33. Date of Death<br><b>7/21/97</b>  |  | 34. Time of Death<br><b>9:40 p m</b>   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23699

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DAVID LYNN DECKER

2. Date of Death

Month Day Year  
July 7 1997

3. Time of Death

15:43

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

49648 Flower of the Forest Rd.

4b. City, Town, or Location of Death

Lexington Park

4c. County of Death

St. Mary

5. Social Security Number

578-64-2978

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

49 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 28, 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

49648 Flower of the Forest Rd.

10f. Zip Code

20653

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Electronics Tech

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Donald Benjamin Decker

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Marie Maxwell

19a. Informant's Name/Relationship (Type, Print)

Steven A. Decker/Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

50295 Fresh Pond Neck Rd., Ridge, MD 20680

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7/8/97

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

*Michael L. Gardiner*

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. *Corrosion of the Liver*  
Due to (or as a consequence of):

Sequitely list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic Alcoholism**Seizure disorder*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*William Boyd*

29c. License number

D14285

29d. Date signed (Month, Day, Year)

7-8-97

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

Dr. William Boyd, II

Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

JUL - 9 1997

32. Registrar's Signature

*John Anderson Randall*State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23700

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |  |  |
|---|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Paul Matthew Dickerson   |  |  |  | 2. Date of Death<br>Month Day Year<br>July 13, 1997   |  | 3. Time of Death<br>7:00a.m.   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>St. Mary's Hospital  |  |  |  | 4b. City, Town, or Location of Death<br>Leonardtwn  |  | 4c. County of Death<br>St. Mary's  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>220-16-5029   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>71 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Sep 19, 1925  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland   |  | 10. Usual Residence of Decedent<br>10e. State: Maryland 10b. County: St. Mary's 10c. City, Town or Location: Loveville 10d. Inside City Limits: <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No If Yes, Give Year or Dates: |  |
| To Be Completed by Funeral Director           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): 12th Grade College (1-4 or 5+):   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver                           |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Allen Dickerson  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Ann Elizabeth Rich  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Vincena C. Dickerson/Wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>27185 Point Lookout Rd., Loveville, MD 20656      |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>St. Joseph Cemetery  |  | 20c. Location - City or Town, State<br>Morganza, MD   |  | 21. Signature of Funeral Service Licensee<br>Michael K. Hardin   |  |
|   | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. metastatic squamous cell carcinoma brain 4uh<br>Due to (or as a consequence of):<br>b. squamous cell carcinoma lung with 2 mo.<br>Due to (or as a consequence of):<br>c. multiple metastases<br>Due to (or as a consequence of):<br>d. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)   |  |
|   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>John F. Fenwick   |  | 29c. License number<br>D01380   |  | 29d. Date signed (Month, Day, Year)<br>7-14-97   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Dr. John F. Fenwick Leonardtown, MD. 20650   |  | 31. Date filed (Month, Day, Year)<br>JUL 15 1997   |  | 32. Registrar's Signature<br>John Davidson Randall  |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23701

## Certificate of Death

Reg. No.

|  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
|--|---|------------------------------|---|---|--|--|---|--|---|----|-------------------------------|---|----|------------------------------|----|--|----|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>BETTY JUNE DRAVER</b>  |                              |   |   | 2. Date of Death<br>Month Day Year<br><b>July 10 1997</b>  |  | 3. Time of Death<br><b>3:00 AM</b>                                      |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>29723 Dogwood Circle</b>   |                              |   |   | 4b. City, Town, or Location of Death<br><b>Mechanicsville</b>  |  | 4c. County of Death<br><b>St. Mary</b>                                  |  |   |    |                               |   |    |                              |    |  |    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>282-22-5140</b>   |                              | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>July 20, 1925</b>             |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Ohio</b>   |                              | 10a. State<br><b>MD</b>   |   | 10b. County<br><b>St. Mary</b>   |  | 10c. City, Town or Location<br><b>Mechanicsville</b>                    |  |   |    |                               |   |    |                              |    |  |    |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                              | 10e. Street and Number<br><b>29723 Dogwood Circle</b>   |   | 10f. Zip Code<br><b>20659</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |                              | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                              | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                     |   | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Charles B. Lechrone</b>   |                              |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Olive B. Drusnell</b>  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Scott Midgett/Son</b>  |                              |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>29723 Dogwood Circle, Mechanicsville, MD 20659</b>                                       |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                              | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |   | 20c. Location - City or Town, State<br><b>7/11/97 Alexandria, VA</b>   |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Michael K. Gardner</b>  |                              |   |   | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, MD 20650</b>  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
|  | <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Cardiomyopathy Failure</b></td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>day</b><br/><b>yrs.</b> </td> </tr> <tr> <td>b.</td> <td><b>Chronic Renal Failure</b></td> </tr> <tr> <td>c.</td> <td></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |                              |   |   |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. | <b>Cardiomyopathy Failure</b> | Approximate Interval Between Onset and Death<br><br><b>day</b><br><b>yrs.</b> | b. | <b>Chronic Renal Failure</b> | c. |  | d. |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a.                           | <b>Cardiomyopathy Failure</b>   | Approximate Interval Between Onset and Death<br><br><b>day</b><br><b>yrs.</b> |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| b.   |   | <b>Chronic Renal Failure</b> |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| c.   |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| d.   |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 29b. Signature and Title of certifier<br><b>James P. Jarboe, MD</b>  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 29c. License number<br><b>D06419</b>   |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 29d. Date signed (Month, Day, Year)<br><b>July 11, 1997</b>  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Patrick Jarboe, MD</b> <b>Hollywood, MD 20636</b>   |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 1997</b>  |   |                              |   |   |  |  |   |  |   |    |                               |   |    |                              |    |  |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



State of Maryland / Department of Health and Mental Hygiene 97 23702

## Certificate of Death

Reg. No.

**Division of Vital Records, P.O. Box 68760,**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23703

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JAMES MORTON ENNIS

2. Date of Death

Month Day Year  
JULY 22, 1997

3. Time of Death

1:49 P.M.

4a. Facility Name (If not institution, give street and number)

6822 2ND STREET

4b. City, Town, or Location of Death

RIVERDALE

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

214-28-9534

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
MAR. 26, 1932

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10e. State

MARYLAND

10b. County

PRINCE GEORGES

10c. City, Town or Location

RIVERDALE

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6822 2ND STREET

10f. Zip Code

20737

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FIRE FIGHTER

16b. Kind of Business/Industry

COUNTY GOVERNMENT

17. Father's Name (First, Middle, Last)

WILLIAM JOSEPH ENNIS

18. Mother's Name (First, Middle, Maiden Surname)

HATTIE J. REES

19a. Informant's Name/Relationship (Type, Print)

MARGARET J. ENNIS, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6822 2ND STREET, RIVERDALE, MARYLAND 20737

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

FORT LINCOLN CEMETERY

Date

7/25/97

20c. Location - City or Town, State

BRENTWOOD, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

FORT LINCOLN FUNERAL HOME

3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one condition on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

4/97

4/97

4/97

to 7/97

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

John Hunter Ruffell

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

*[Illegible handwritten signature]*

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23704

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |   |  |
|--|--|--|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>VIRGINIA EDMONDSON</b>                                  |  |   |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>7</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>2:12am</b>  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>TAKOMA PARK</b>   |  | 4c. County of Death<br><b>MONTGOMERY</b>   |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>259-34-1570</b>  |  | 6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br><b>91</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 26 1906</b>                                     |   |  |
|  | 10e. State<br><b>--</b>  |  | 10b. County<br><b>--</b>  |   | 10c. City, Town or Location<br><b>WASHINGTON, D.C.</b>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>5736 2nd STREET, N.E.</b>   |  |  |   | 10f. Zip Code<br><b>20011</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                        |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  |  |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>   |  | 16b. Kind of Business/Industry<br><b>HOME</b>                                |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>HILLARD GRAY</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HESTER SMITH</b>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>CLARINDA HINNANT DAUGHTER</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3205 SAVILLE LANE MITCHELLVILLE, MD 20721</b>   |  |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>EVERGREEN CEMETERY</b>   |   | Date<br><b>7-15-97</b>   |  | 20c. Location - City or Town, State<br><b>UNADILLA, GA</b>                                     |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Theresa Johnson-Salley</i>   |  |  |   | 22. Name and Address of Facility<br><b>CAPITOL MORTUARY, INC.<br/>1425 MARYLAND AVE., NE WASH., DC 20002</b>  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>CARCINOMA BREAST</b>   |  |  |   |   |  |  |  |   |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |   |  |  |  |   |  |
| 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |   |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Homicide  |  |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28d. Describe how injury occurred  |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   | 29b. Signature and title of certifier<br><i>Jeffrey Kelman</i>  |  | 29c. License number<br><b>20391</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 23, 1997</b>                                 |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. JEFFREY KELMAN 6525 BELCREST RD. STE. #208 HYATTSVILLE, MD.</b>   |  |  |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>  |  |  |   | 32. Registrar's Signature<br><i>Jane Sullivan-Randall</i>   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23705

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLIVER ELLIS, JR

2. Date of Death

Month JULY

Day 16

Year 1997

3. Time of Death

11:00AM

4a. Facility Name (If not institution, give street and number)

1713 FIENWOOD AVENUE

4b. City, Town, or Location of Death

OXON HILL

4c. County of Death

PRINCE GEORGES

Funeral  
Director

5. Social Security Number

314-28-8992

6. Sex

F

7. Age (In yrs. last birthday)

63

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 16, 1933

9. Birthplace (State or Foreign Country)

Evansville, IN.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Oxon Hill

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1713 Fenwood Ave.

10f. Zip Code

20745

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? ☒ Yes ☐ No Retired

If Yes, Give Year or Dates: 1973

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

USAF and Teacher

16b. Kind of Business/Industry

Military &amp; D.C. School System

17. Father's Name (First, Middle, Last)

Oliver Roy Ellis, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Dorothy Dulin

19a. Informant's Name/Relationship (Type, Print)

Lauretta M. Ellis/Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Same as item 10

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cem. 7/22/97

Date

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

George P. Kalas Funeral Home

6160 Oxon Hill Rd. Oxon Hill, Md. 20745

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

DMED 33954

29d. Date signed (Month, Day, Year)

7-17-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARIO P. GOLIE JR MD 3801 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23706

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marguerite Fleshman

2. Date of Death

Month  
JulyDay  
18,Year  
1997

3. Time of Death

12:00 pm

4a. Facility Name (If not institution, give street and number)

14803 Carrollton Road

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

5. Social Security Number

216-10-5687

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 13, 1918

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

151 Interlachen Drive

10f. Zip Code

20906

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Robert Franklin Mattingly, Jr.

18. Mother's Name (First, Middle, Maiden Surname)

Alice Virginia Leedy

19a. Informant's Name/Relationship (Type, Print)

Alice Mennitt - Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14803 Carrollton Road, Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

07/21/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. WALDENSTROM'S MACROGLOBULINEMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 1/2 years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES D. BROWN, MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE, MARYLAND 20853

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Andrew Ruckel

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Handwritten text at the bottom of the page, possibly a signature or date.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23707  
Certificate of Death

Reg. No.

|   |   |   |   |  |   |   |  |  |  |
|---|---|---|---|--|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Catherine M Fowler</i>   |   |   |  | 2. Date of Death<br>Month <i>July</i> Day <i>19</i> Year <i>1997</i>  |   | 3. Time of Death<br><i>6:33am</i>  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Southern Maryland Hospital</i>   |   |   |  | 4b. City, Town, or Location of Death<br><i>Clinton</i>  |   | 4c. County of Death<br><i>Prince George's</i>  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>578-54-2006</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><i>78</i> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><i>JULY 4, 1919</i>                                     | 9. Birthplace (State or Foreign Country)<br><i>VIRGINIA</i>  |  |
|   | Usual Residence of Decedent   |   |   |  | 10c. City, Town or Location<br><i>WASHINGTON, D.C.</i>  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director   | 10e. State<br><i>DC</i>   |   | 10b. County   |  | 10f. Zip Code<br><i>20018</i>   |   | 10g. Citizen of What Country?<br><i>UNITED STATES AMERICA</i>                                  |  |  |
|   | 10e. Street and Number<br><i>2412 FRANKLIN ST. N.E. APT. 509</i>  |   |   |  | 10f. Zip Code<br><i>20018</i>   |   | 10g. Citizen of What Country?<br><i>UNITED STATES AMERICA</i>                                  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>BLACK</i>                        |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12th GRADE</i>  |   | College (1-4 or 5+)   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>HOME MAKER</i>  |   | 16b. Kind of Business/Industry<br><i>PRIVATE</i>   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><i>WILLIAM MC KINNEY</i>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>ANNA ANDERSON</i>   |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><i>ARTHUR B. STEWART (SON)</i>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>1034 CREST HAVEN DR., SILVER SPRING, MD. 20903</i>  |   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>HARMONY MEM. PK.</i>   |  | Date<br><i>7-23-97</i>  |   | 20c. Location - City or Town, State<br><i>LANDOVER, MD.</i>                                    |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |  | 22. Name and Address of Facility<br><i>JOHNSON &amp; JENKINS INC.<br/>716 KENNEDY ST. N.W. W.D.C. 20011</i>   |   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Septicemia</i><br>Due to (or as a consequence of):<br><i>Myocardial infarct - S/P CABG</i><br><i>5 years</i><br><i>Sepsis Discharge</i><br><i>May years</i><br><i>End stage renal</i><br><i>may years</i> |   |   |  |   |   |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Dilated cardiomyopathy - complicated by peripheral vascular disease</i><br><i>S/P Angiogram</i>  |   |   |   |  |   | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                         |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No           |  | 28d. Describe how Injury occurred  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>K. Danachi MD</i>   |   | 29c. License number<br><i>D25640</i>             |   | 29d. Date signed (Month, Day, Year)<br><i>7/19/97</i>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><i>Khosrow Danachi MD 1328 Southern Ave. #202 WASH. DC</i> |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 23 1997</i>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |   |   |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23708

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |  |  |
|---|--|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedant's Name (First, Middle, Last)<br>Lawrence Samuel Ferrell  |  |  |  | 2. Date of Death<br>Month Day Year<br>July 20 1997  |  |   |  | 3. Time of Death<br>2:00 A.M.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>1502 Pernell Court   |  |  |  | 4b. City, Town, or Location of Death<br>Bowie   |  |   |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>577 18 2116   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>74 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Aug. 30, 1922  |  | 9. Birthplace (State or Foreign Country)<br>North Carolina                                     |  |
|   | Usual Residence of Decedant  |  |  |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director           | 10a. State<br>Maryland   |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Bowie  |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>1502 Pernell Court   |  |  |  | 10f. Zip Code<br>20716  |  | 10g. Citizen of What Country?<br>United States  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WWII |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+)   |  |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Salesman   |  |   | 16b. Kind of Business/Industry<br>Automotive                     |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Y. Pharis Ferrell   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bernice Medlin   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Myrna W. Ferrell Wife  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1502 Pernell Court Bowie Maryland 20716  |  |   |  |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory   |  |   |  | Date<br>July 23 1997  |  | 20c. Location - City or Town, State<br>Alexandria Virginia                                     |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br>Robert E. Evans Funeral Home, Inc.<br>16000 Annapolis Rd. Bowie Md. 20715   |  |   |  |  |  |
|   | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cardio - Resp. Arrest.<br>Due to (or as a consequence of):<br>b. Dilated Cardiomyopathy.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |   |  |   |  |  |  |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |  |  |
|   | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br>D30769   |  | 29d. Date signed (Month, Day, Year)<br>7/22/97  |  |  |  |
| State<br>Registrar                            | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>RAKESH C. SAHNI 7715 Belle Point Dr, Greenbelt, MD   |  |  |  |   |  |   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br>JUL 24 1997   |  |  |  | 32. Registrar's Signature<br>20770  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

97 23709

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

THOMAS A. FARRINGTON

2. Date of Death

Month

Day

Year

3. Time of Death

7

19

97

1841 P.M.

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

577 52 7401

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

June 25, 1938

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Mitchellville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2812 Spriggs Request Way

10f. Zip Code

20721

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 63-65

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Attorney

16b. Kind of Business/Industry

Law

17. Father's Name (First, Middle, Last)

C. Max Farrington

18. Mother's Name (First, Middle, Maiden Surname)

Lydia Wilson

19a. Informant's Name/Relationship (Type, Print)

Deborah S. Farrington Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2812 Spriggs Request Way Mitchellville Md. 20721

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Oddfellows Cemetery July 23, 1997 Milton Delaware

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael L. Sigler

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIOGENIC SHOCK

Due to (or as a consequence of):

2 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. LOW CARDIAC OUTPUT

Due to (or as a consequence of):

2 DAYS

c. ACUTE SEPTAL RUPTURE

Due to (or as a consequence of):

2 DAYS

d. MASSIVE MYOCARDIAL INFARCTION

2 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MULTIPLE ORGAN FAILURE.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Samir R. Neimat, MD.

29c. License number

18551 MD

29d. Date signed (Month, Day, Year)

JULY 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

SAMIR R. NEIMAT, MD. 7610 CARROLL AV. TAKOMA PARK, MD, 20912

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

John A. Carroll

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

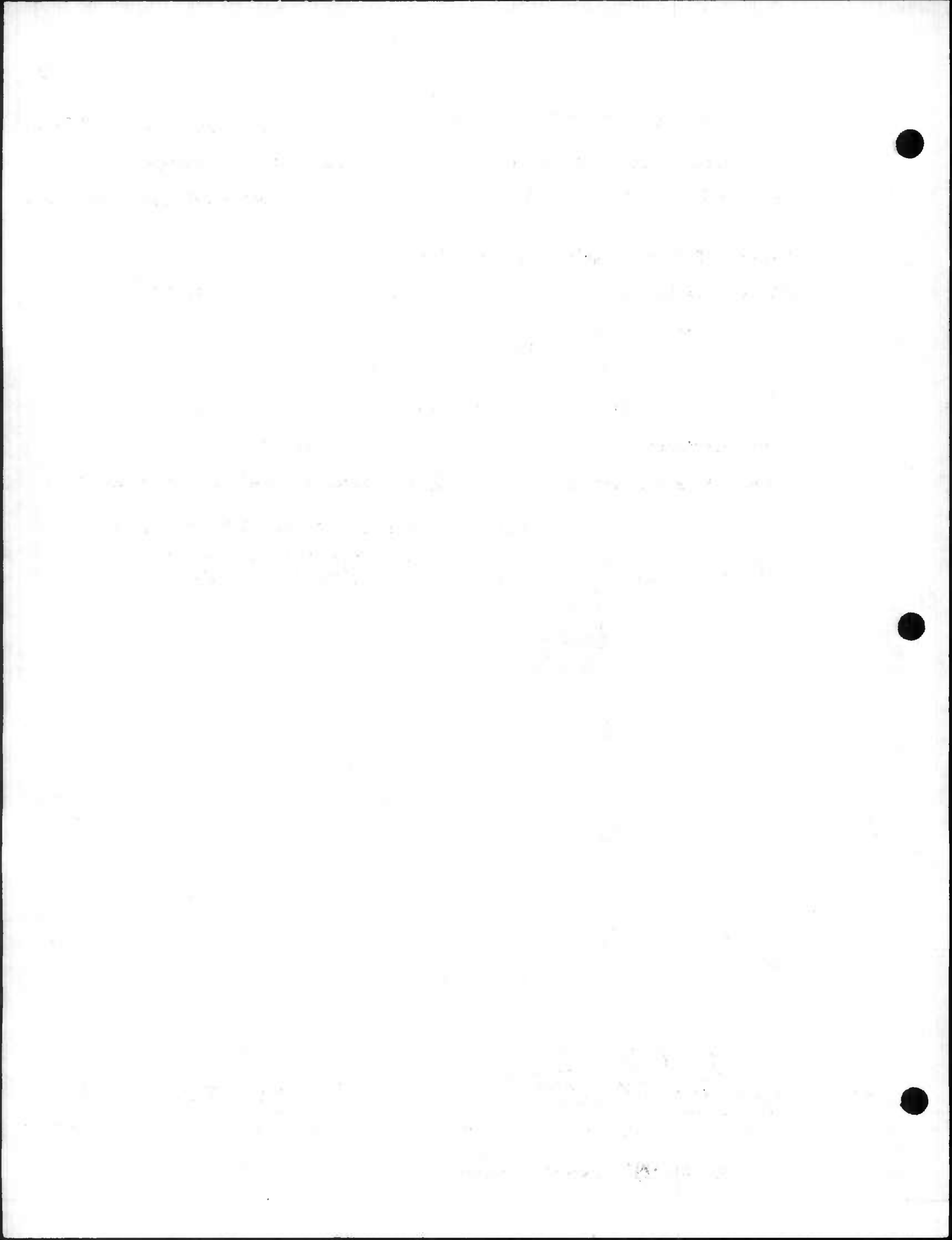
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23710

Certificate of Death

Reg. No.

|  |   |   |   |                                      |  |   |  |   |
|--|---|---|---|--------------------------------------|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Irene Stasz Fitzpatrick</b>  |   |   |                                      | 2. Date of Death<br>Month Day Year<br><b>July 21 1997</b>  |   | 3. Time of Death<br><b>7:50 PM</b>   |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Circle Manor Nursing Home</b>  |   |   |                                      | 4b. City, Town, or Location of Death<br><b>Kensington</b>  |   | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>039-30-0107</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 25, 1908</b>                                 |  | 9. Birthplace (State or Foreign Country)<br><b>Rhode Island</b> |
|  | Usual Residence of Decedent   |   |   |                                      |  |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Montgomery</b>  |                                      | 10c. City, Town or Location<br><b>Kensington</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>9508 West Stanhope Road</b>  |   |   |                                      | 10f. Zip Code<br><b>20895</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>                       |                                      | 16b. Kind of Business/Industry<br><b>Education</b>   |   |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Stasz</b>  |   |   |                                      | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Pauline Bryda</b>  |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kathleen Fitzpatrick May</b>   |   |   |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9508 West Stanhope Road Kensington, Maryland 20895</b>                                   |   |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Charles Cemetery</b>   |                                      | Data<br><b>7/28/97</b>   |   | 20c. Location - City or Town, State<br><b>Blackstone, Massachusetts</b>                        |   |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |                                      | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc.<br/>500 University Blvd., W., Silver Spring, MD 20901</b>   |   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Pneumonia</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____ |   |   |                                      |  |   |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Alzheimer's dementia</b>   |   |   |                                      |  |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |                                      |  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |                                      |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |                                      |  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                      |  |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>      |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                               |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>D34032</b> |  | 29d. Date signed (Month, Day, Year)<br><b>7/23/97</b>                                       |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JEANNE P. ASHLE 3720 FARRAGUT AVE KENSINGTON MD 20895</b>   |   |   |   |                                      |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |                                      |  |   |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23711

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Hunter A. Fitzgerald

2. Date of Death

Month Day Year  
July 18, 1997

3. Time of Death

10:00AM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

5. Social Security Number

566-36-3092

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 6, 1931

9. Birthplace (State or Foreign Country)

California

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3504 Glenmoor Drive

10f. Zip Code

20815

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1953-1955

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Foreign Service Officer

16b. Kind of Business/Industry

United States

Government

17. Father's Name (First, Middle, Last)

Wallace Fitzgerald

18. Mother's Name (First, Middle, Maiden Summa)

Mona Dunn

19a. Informant's Name/Relationship (Type, Print)

Estela S. Fitzgerald / wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3504 Glenmoor Drive, Chevy Chase, Maryland 20815

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

July 20, 1997

Montgomery Crematorium, Inc.

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.  
7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. *Ventricular arrhythmia*

Due to (or as a consequence of):

240

b. *ischemic heart disease*

Due to (or as a consequence of):

1 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael Kinner 5754 Wisconsin Ave Chevy Chase MD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

Hunter A. Fitzgerald 7/18/97 10a.m.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23712

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ann NORAH

Fitzgerald

2. Date of Death

July 22 1997

3. Time of Death

8:25pm

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

061-28-2533

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

62 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 22, 1935

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

618 Muriel Street

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

John J. Crehan

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Shea

19a. Informant's Name/Relationship (Type, Print)

Michael Fitzgerald

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

790 Kimberly Court East, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

7/29/97

20c. Location - City or Town, State

Arlington, VA

21. Signature of Funeral Service Licensee

*Eric S. Scrubs*

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC BREAST CANCER

11 MONTHS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. c. d.

Due to (or as a consequence of):

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Carolyn Hendricks MD*

29c. License number

037236

29d. Date signed (Month, Day, Year)

JULY 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN HENDRICKS MD #300 ROCKVILLE MD 20815  
9707 MEDICAL CENTER DRIVE

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

*Davidson-Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-f show injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23713

Sherman Irving Fleming, Sr.

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHERMAN I. FLEMING

2. Date of Death

Month 6 Day 28 Year 97

3. Time of Death

2:10 p.m.

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

230-12-4981

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 9, 1923

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State  
Maryland10b. County  
St. Mary's10c. City, Town or Location  
Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

46068 East Sunrise Drive

10f. Zip Code

20653

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1943-1967

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collegiate (14 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Non-commissioned officer

16b. Kind of Business/Industry

U.S. Navy/Defense

17. Father's Name (First, Middle, Last)

Eddie Fleming

18. Mother's Name (First, Middle, Maiden Summa)

Florence Fleming

19a. Informant's Name/Relationship (Type, Print)

Dolores M. Fleming, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

46068 East Sunrise Drive., Lexington Park, Maryland 20653

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington National Cemetery

Date

7-8-1997

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Director

Michael K. Blankenship, MO0852

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, Maryland 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. METABOLIC &amp; RESPIRATORY ACIDOSIS

5 DAYS

Due to (or as a consequence of):

b. RESPIRATORY FAILURE

MONTHS

Due to (or as a consequence of):

c. CORD, and BULLOUS EMPHYSEMA, #

YEARS

Due to (or as a consequence of):

d. RENAL FAILURE

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (disease or injury that initiated events resulting in death) last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BLADDER CA = ILEOSTOMY.

NEPHRECTOMY for CALCULUS AS

REMOTE TB. MULTIFOCAL ATRIAL TH.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S.D. KRIVICKAS, M.D.

900 BOSTWICK RD

BOWTICK, MD.

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JUL -2 1997 Julia Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. If item 27 is marked other than "natural", or item 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

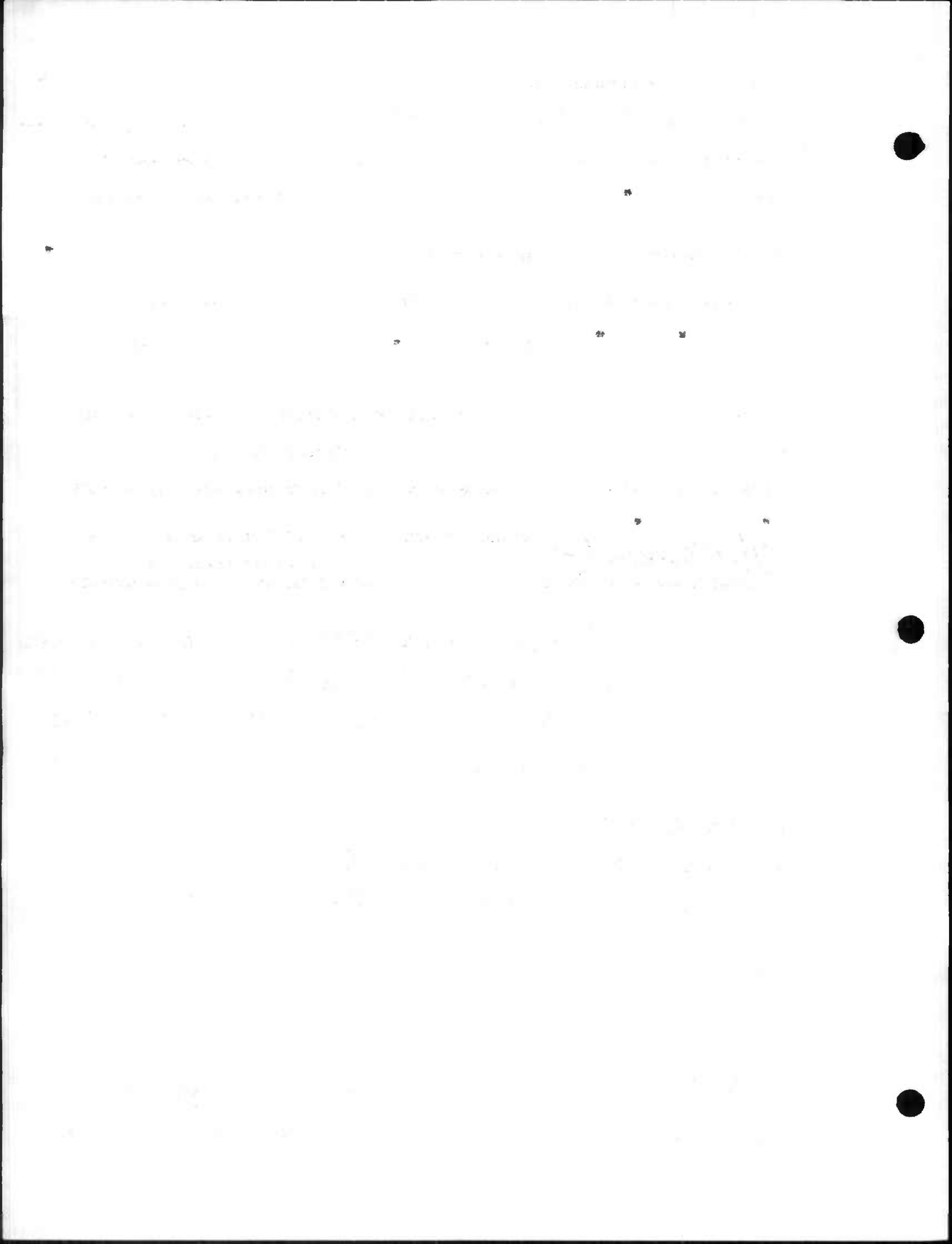
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Amended #8, 7-16-97, BT, St. Mary's Co.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23714

|   |  |                                  |   |  |  |  |   |  |   |  |
|---|--|----------------------------------|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mildred Stephanie Forbes</b>                  |                                  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>July 13, 1997</b>                                  |  | 3. Time of Death<br><b>12:47 Am</b>                         |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b> |                                  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtwn</b>                                   |  | 4c. County of Death<br><b>St. Mary's</b>                    |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-82-6580</b>  |                                  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb 24, 1961</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |
|   | Usual Residence of Decedent  |                                  |   |  |  |  |   |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>St. Mary's</b> |   | 10c. City, Town or Location<br><b>Hollywood</b>  |  |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 10e. Street and Number<br><b>23889 Tin Top Hill Lane</b>  |  |                                  |   | 10f. Zip Code<br><b>20636</b>  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12th Grade</b>  |  |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Loan Clerk</b> |  |  | 16b. Kind of Business/Industry<br><b>Bank</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert Alexander Brooks</b>   |  |                                  |   |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Genevieve Queen</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Louis E. Forbes, Jr./Spouse</b>  |  |                                  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>23889 Tin Top Hill Lane, Hollywood, MD 20636</b> |   |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Charles Memorial Gardens</b>   |  |  | 20c. Date<br><b>7/18/97</b>  |   | 20d. Location - City or Town, State<br><b>Leonardtwn, MD</b>                                   |   |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>   |  |                                  |   |  |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>                      |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Severe Asthma</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |                                  |   |  |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |                                  |   |  |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |                                  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |
|   |  |                                  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |                                  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  |                                  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |
|   |  |                                  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |   |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |                                  |   |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br><i>David C. Allen M.D.</i>   |  |                                  |   |  |  | 29c. License number<br><b>D25230</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>7/14/97</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David C. Allen, M.D. California, Maryland 20619</b>  |  |                                  |   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 15 1997</b>   |  |                                  |   |  |  |  |   |  |   |  |
| 32. Registrar's Signature<br><i>John Andrew Randall</i>   |  |                                  |   |  |  |  |   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23715

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James Frank Fenwick

2. Date of Death

Month Day Year  
July 21 1997

3. Time of Death

1:49 P.M.

4a. Facility Name (If not Institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

216-24-1207

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

68 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug 1, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13 Bristol Avenue

10f. Zip Code

20653

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
6th Grade

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Frank Sylvester

Fenwick

18. Mother's Name (First, Middle, Maiden Surname)

Mag Barber

19a. Informant's Name/Relationship (Type, Print)

Agnes Diane Campbell/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13 Bristol Avenue, Lexington Park, MD 20653

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Immaculate Heart of Mary

Date

7/26/97

20c. Location - City or Town, State

Lexington Park, MD

21. Signature of Funeral Service Licensee

Michael L. Lachline

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.

P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

a. *Cardiopulmonary Failure*  
Due to (or as a consequence of):

b. *Metabolic Acidosis*  
Due to (or as a consequence of):

c. *Chronic Renal Failure*  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

hs  
days  
was

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Carcinoma of Cecum*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*James P. Jarboe M.D.*

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

7-22-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES P. JARBOE M.D.

LEONARDTOWN, MD. 20650

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

*John Anderson Randall*

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
410-388-6000.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

JAMES FRANKLIN FENWICK  
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Item 23 Part II Per PHY Film G758 4-15-98 **Certificate of Death**

Reg. No.

97 23716

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lucille M. Garner

2. Date of Death

Month 7 Day 21 Year 1997

3. Time of Death

2:30AM

4a. Facility Name (If not institution, give street and number)

Kent &amp; Queen Anne's Hospital

4b. City, Town, or Location of Death

Chestertown

4c. County of Death

Kent

Funeral  
Director

5. Social Security Number

084-20-0404

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
7-02-1922

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

Queen Anne's

10c. City, Town or Location

Centreville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

205 Armstrong Ave.

10f. Zip Code

21617

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
(08)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cleaner Dry

16b. Kind of Business/Industry

Beatrice Cleaner

17. Father's Name (First, Middle, Last)

Olivier Tate

18. Mother's Name (First, Middle, Maiden Surname)

Laura Garner

19a. Informant's Name/Relationship (Type, Print)

Mary Jane Cornish (Friend)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 136 Queenstown, Md. 21658

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NCCOL Cem.

Date

7-25-97

20c. Location - City or Town, State

Worton, Md.

21. Signature of Funeral Service Licensee

MOOSIO

22. Name and Address of Facility

WALLEY FUNERAL HOME

207 Calvert St. Chestertown, Md. 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Status Epilepticus  
Due to (or as a consequence of):

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

24 hours

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① LUL Pneumonia ② Multi-infarct  
Dementia ③ Lyme Disease by history

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

L. U. Ulem, MD

29c. License number

D21313

29d. Date signed (Month, Day, Year)

7/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kue Kin Wun M.D. 223 High St. Chestertown, Maryland 21620

31. Date filed (Month, Day, Year)

JUL 23

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23717

Amended # 18. P.G.C. 7-28-97 cr

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ursula Elizabeth Gray

2. Date of Death

Month  
JulyDay  
19Year  
1997

3. Time of Death

3:30am

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

217-36-9564

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

March 2, 1906

9. Birthplace (State or Foreign Country)

Whitfield, VA

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

X ☒ Yes 2 ☐ No

10e. Street and Number

2612 Belle Crest Lane

10f. Zip Code

20906

10g. Citizen of What Country?

USA

11. Marital Status

X ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

College (6)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Teacher

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

William Gray

18. Mother's Name (First, Middle, Maiden Surname)

Mary Lyles Harris

19a. Informant's Name/Relationship (Type, Print)

Debra Broadus Great Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2612 Belle Crest Lane Silver Spring, MD 20906

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt. Olivet

Date

July 23, 1997

20c. Location - City or Town, State

Wash., DC

21. Signature of Funeral Service Licensee

Reginald E. Collier

22. Name and Address of Facility

William F. Magruder 2311 MLK Jr., Ave. SE Wash.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Pneumonia

Due to (or as a consequence of):

sepsis

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mohammed A. Khelid, MD

29c. License number

D43496

29d. Date signed (Month, Day, Year)

7-19-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed A. Khelid MD 8830 - Camem Court Suite 502 Silver Spring MD 20910

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

perm. it. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

111



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23718

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

OLETA

U-

GLANZER

2. Date of Death

Month Day Year

July 23 1997

3. Time of Death

8:50 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

227-03-8219

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

May 30, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

10 ☒ Yes 2 ☐ No

10e. Street and Number

907 Heather Ave.

10f. Zip Code

20912

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

William Ross

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Simmons

19a. Informant's Name/Relationship (Type, Print)

Eugene C. Glanzer/husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

907 Heather Ave. Takoma Park, MD 20912

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory 7/24/97

Date

20c. Location - City or Town, State

Alexandria, VA

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home, Inc.

254 Carroll St. NW Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CEREBRAL STROKE

Approximate Interval Between Onset and Death

6 days

Due to (or as a consequence of):

b. HYPERTENSION

Year

Due to (or as a consequence of):

c. ATHEROSCLEROTIC HEART DISEASE

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE

DEMENCIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19971

29d. Date signed (Month, Day, Year)

July 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. KEMFANNA SUDHAKAN 7610 CARROLL AVE T.P. MD 20912

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23719

Amended #10e, 7/25/97, JW, Montg. Cty.

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AGNES ELENE GRAHAM

2. Date of Death

Month Day Year  
JULY 21, 1997

3. Time of Death

3:30 AM

4e. Facility Name (If not institution, give street and number)

15505 QUINCE ORCHARD ROAD

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

220-38-4164

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
APR 6, 1941

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

GERMANTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12506

10f. Zip Code

20874

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BUDGET ANALYST

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

ELLIS SHEETS

18. Mother's Name (First, Middle, Maiden Surname)

BERTIE BLEVINS

19a. Informant's Name/Relationship (Type, Print)

KIMBERLY HORN, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11519 ALDBURG WAY, GERMANTOWN, MD 20876

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PARKLAWN MEMORIAL PARK

Date

JULY 23, 1997

20c. Location - City or Town, State

ROCKVILLE, MARYLAND

21. Signature of Funeral Service Licensee

Michael D. Hillons

22. Name and Address of Facility

DEVOL FUNERAL HOME

10 EAST DEER PARK DR., GAITHERSBURG, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC NONSMALL CELL LUNG CANCER

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 WEEKS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient

2 ☐ ER/Outpatient

3 ☐ DOA

Other:

4 ☐ Nursing Home

5 ☐ Residence

6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician

2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Carolyn B. Hendricks MD

29c. License number

D37236

29d. Date signed (Month, Day, Year)

JULY 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CAROLYN B. HENDRICKS MD 9707 MEDICAL CENTER DRIVE ROCKVILLE MD

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 23720

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>HANNAH GROSSMAN</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>July 22, 1997</b>   |  | 3. TIME OF DEATH<br>HOUR MIN.<br><b>5:40 P M</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>087-22-4408</b>   |  | 5. SEX<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br><b>81</b> YRS.   |  | 7. DATE OF BIRTH (Month, Day, Year)<br><b>Nov. 9, 1915</b>   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br><b>New York</b>   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br><b>Hebrew Home of Greater Washington</b>   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>  |  |
| 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |  |  | 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Montgomery</b>   |  |
| 10c. CITY, TOWN OR LOCATION<br><b>Rockville</b>   |  |  |  | 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br><b>6121 Montrose Rd.</b>   |  |
| 10f. ZIP CODE<br><b>20852</b>   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>  |  | 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br><b>Proprietor/Owner</b>  |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Heating/ Air Conditioning</b>   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Joseph Isaac Jolles</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Esther Perlin</b>  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Barbara Chizever (Daughter)</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 Duke St. South, Rockville, MD. 20850</b>  |  |  |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Judean Gardens 7-25-97</b>   |  | 20c. LOCATION — City or Town, State<br><b>Olney, Maryland</b>  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Frank A. Stone</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>Danzansky-Goldberg Mem. Chapels, Inc.<br/>1170 Rockville Pike, Rockville, MD 20852</b>  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ISCHEMIC CARDIOMYOPATHY</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>ISCHEMIC CARDIOMYOPATHY</b><br>b. <b>—</b><br>c. <b>—</b><br>d. <b>—</b><br>Approximate Interval Between Onset and Death<br><b>3 YEARS</b> |  |  |  |  |  |  |  |
| 23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></b>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M <input type="checkbox"/> YES <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  | 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>A. L. ...</i> <b>Attending Physician</b>   |  | 29c. LICENSE NUMBER<br><b>D18084</b>   |  |
| 29d. DATE SIGNED (Month, Day, Year)<br><b>JULY 23, 1997</b>   |  |  |  | 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>D.D. PATEL, M.D. 6121 MONTROSE RD, Rockville, MD 20852</b>   |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 24 1997</b>   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Rendell</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23721

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNA GREENFIELD

2. Date of Death

JULY 23 1997

3. Time of Death

7:20AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

164-26-2596

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JANUARY 9, 1901

9. Birthplace (State or Foreign Country)

SLOVAKIA

Usual Residence of Decedent

10e. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6105 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

SAMUEL MELLER

18. Mother's Name (First, Middle, Maiden Surname)

FANNIE STEINBERG

19e. Informant's Name/Relationship (Type, Print)

CATHERINE LINER -- DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2933 TERRACE DRIVE, CHEVY CHASE MD 20815

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

JUDEAN MEMORIAL GARDENS

Date

7/25/97

20c. Location - City or Town, State

OLNEY, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC  
1170 ROCKVILLE PIKE, ROCKVILLE, MD 2085223e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Due to (or as a consequence of):

MULTI-INFARCT DEMENTIA

Approximate  
Interval Between  
Onset and Death

10 YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined

28e. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of Certifier

 D.D. Patel, M.D. 6121 MONTROSE RD, Rockville, MD 20852

29c. License number

D18084

29d. Date signed (Month, Day, Year)

JULY 23, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

D.D. PATEL, M.D. 6121 MONTROSE RD, Rockville, MD 20852

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23722

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Wilson Gray

2. Date of Death

Month Day Year  
June 26, 1997

3. Time of Death

1525

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Patuxent River Naval Hospital

4b. City, Town, or Location of Death

Patuxent River

4c. County of Death

St. Mary's

5. Social Security Number

220-34-7913

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
August 18, 1939

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Loveville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

40616 Rudys Lane

10f. Zip Code

20656

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1963-196513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working  
life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Edward Curtis

18. Mother's Name (First, Middle, Maiden Surname)

Elizabeth Gray

19a. Informant's Name/Relationship (Type, Print)

Velda Ragland, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3206 Kings Way Road, Fort Washington, MD 20744

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Queen of Peace

Date

7/2/97

20c. Location - City or Town, State

Helen, Maryland

21. Signature of Funeral Service Licensee

Edward N. Brinsfield, Jr. M00052

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Probable Myocardial Infarction Sec  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

William Boyd II, M.D.

29c. License number

D14285

29d. Date signed (Month, Day, Year)

7-1-97.

30. Name and address of person who completed cause of death (item 23e) (Type, Print)

William Boyd II, M.D. 25365 Point Lookout Road, Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

JUL -2 1997

32. Registrar's Signature

John Davidson, R.D. II.

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23723

## Certificate of Death

Reg. No.

|  |  |  |   |                                 |   |
|--|--|--|---|---------------------------------|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Elmer Marcellus Gatton, Sr.</b>   |  | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1997</b>  |                                 | 3. Time of Death<br><b>7:30 PM</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>25294 Vista Road</b>  |  | 4b. City, Town, or Location of Death<br><b>Hollywood</b>  |                                 | 4c. County of Death<br><b>St. Mary's</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-16-0397</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Sep 12, 1919</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |                                 |   |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  |   |                                 |   |
|  | 10a. State<br><b>Maryland</b>  | 10b. County<br><b>St. Mary's</b>   | 10c. City, Town or Location<br><b>Hollywood</b>   |                                 | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 10e. Street and Number<br><b>25294 Vista Road</b>  |  | 10f. Zip Code<br><b>20636</b>   |                                 | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8th Grade</b> College (1-4 or 5+)               |                                 |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>   |  | 16b. Kind of Business/Industry<br><b>Farm</b>   |                                 |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Oscar Starr Gatton</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Mariah Dean</b>   |                                 |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Abbie L. Gatton/Spouse</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>25294 Vista Road, Hollywood, MD 20636</b>     |                                 |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Joy Chapel Cemetery</b>  |                                 | 20c. Location - City or Town, State<br><b>7/24/97 Hollywood, MD</b>   |
|  | 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>  |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>                   |                                 |   |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Carcinoma of lungs x 10 months</b>   |  |   |                                 | Approximate Interval Between Onset and Death  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>(OPD), PNEUMONIA</b>   |  |   |                                 | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                 | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br><b>M</b> | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |                                 |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                 |   |
|  | 29b. Signature and title of certifier<br><i>KM</i> MD  |  | 29c. License number<br><b>D36206</b>  |                                 | 29d. Date signed (Month, Day, Year)<br><b>07/21/97</b>  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Kiran Mehta, M.D. Shanti Medical Center, Leonardtown, MD 20650</b>  |  |   |                                 |   |
|  | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |  | 32. Registrar's Signature<br><i>John Andrew Randall</i>   |                                 |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23724

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Genevieve Guy

2. Date of Death

Month Day Year  
July 23, 1997

3. Time of Death

5:20 AM

4a. Facility Name (If not institution, give street and number)

St. Mary's Nursing Center

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

217-32-3864

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec 25, 1909

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

820 Old Route Five

10f. Zip Code

20659

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Andrew John Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Mary Castilla Mattingly

19a. Informant's Name/Relationship (Type, Print)

William A. Guy/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

28207 Old Village Road, Mechanicsville, MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Joseph Cemetery

Date

7/26/97

20c. Location - City or Town, State

Morganza, MD

21. Signature of Funeral Service Licensee

Michael L. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

Cardiopulmonary Failure

Due to (or as a consequence of):

Myocardial Failure

Due to (or as a consequence of):

Coronary Artery Disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

hxs  
days  
yes

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial fibrillation

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DCA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. Patrick Jarboe, M.D.

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

7-24-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Patrick Jarboe, M.D.

Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23725

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY S. HARVEY

2. Date of Death

Month Day Year  
JULY 13, 1997

3. Time of Death

7:00 a.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

214 S. Sassafras Street (At Home)

4b. City, Town, or Location of Death

Millington

4c. County of Death

Kent

5. Social Security Number

140-20-2287

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

70

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

August 21, 1926

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Kent

10c. City, Town or Location

Millington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

214 S. Sassafras Street

10f. Zip Code

21651

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Registered Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Ellwood Sheip

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Randall

19a. Informant's Name/Relationship (Type, Print)

Howard L. Harvey/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. Box 281, Millington, Maryland 21651

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Chesapeake Cremation Center, LLC

Date

July 14, 1997

20c. Location - City or Town, State

Stevensville, Maryland

21. Signature of Funeral Service Licensee

*Jay B. Fellows*

22. Name and Address of Facility

Fellows, Helfenbein & Newnam Funeral Home, P.A.  
130 Speer Road, Chestertown, Maryland 21620

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Cardiopulmonary Arrest*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. *Neurostatic Endometrial Carcinoma to Omentum, Peritoneum + Colon*

Due to (or as a consequence of):

c. \_\_\_\_\_

Due to (or as a consequence of):

d. \_\_\_\_\_

Approximate interval between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Peripheral Vascular Disease, History of Right Hemiparesis, History of TIA.*

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

None

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*John L. Arreaga Jr.*

29c. License number

23889

29d. Date signed (Month, Day, Year)

7/14/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John L. Arreaga Jr. MD, 948 Washington Ave, Chestertown MD 21620

31. Date filed (Month, Day, Year)

JUL 15 '97

32. Registrar's Signature

*John Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

40



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State of Maryland / Department of Health and Mental Hygiene

97 23726

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>William J. Hill</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>9:49 P.M.</b>                                    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS HOSPICE AT MERCY HOSPITAL</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-07-1416</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAY 30, 1910</b>              |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, DC</b>  |  | 10a. State  |  | 10b. County  |  | 10c. City, Town or Location<br><b>WASHINGTON, D.C.</b>                  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>4430 KANE PLACE, N.E.</b>  |  | 10f. Zip Code<br><b>20019</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PARK RANGER</b>                    |  | 16b. Kind of Business/Industry<br><b>U.S. PARK SERVICE</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN HILL</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LURENE BANKS</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>ROBERT W. HILL, SON</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10514 S. ABERDEEN, CHICAGO, ILLINOIS 60643</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>FORT LINCOLN CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>7/26/97 BRENTWOOD, MARYLAND</b>  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>James Johnson</i>  |  |   |  | 22. Name and Address of Facility<br><b>FORT LINCOLN FUNERAL HOME<br/>3401 BLADENSBURG RD., BRENTWOOD, MARYLAND 20722</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Rectal Cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |  |  |  |   |  |
| 26. Place of Death (Check only one) <b>Stella Maris at Mercy</b><br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>   |  |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br><i>Dr. [Signature]</i>   |  | 29c. License number<br><b>040480</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>July 21, 1997</b>                  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Fernando J. Perez, MD</b>  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>                                |   | 32. Registrar's Signature<br><i>John [Signature]</i>                         |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



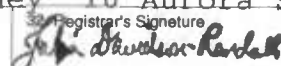
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23727

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |   |  |  |  |
|--|---|---|---|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Effie Lee Hardy Hoffler   |   |   |  | 2. Date of Death<br>7/10/97 Day Year   |   | 3. Time of Death<br>1:05 pm                                      |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Dorchester General Hospital   |   |   |  | 4b. City, Town, or Location of Death<br>Cambridge  |   | 4c. County of Death<br>Dorchester                                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>238-01-0973  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>84 Yrs.   | 8. Date of Birth (Month, Day, Year)<br>5/16/13 | 9. Birthplace (State or Foreign Country)<br>North Carolina   |   |  |  |  |
|  | Usual Residence of Decedent   |   |   |  |  |   |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Md  | 10b. County<br>Dorchester   | 10c. City, Town or Location<br>Preston  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |
|  | 10e. Street and Number<br>6778 Statum Road  |   |   | 10f. Zip Code<br>21655                         |  | 10g. Citizen of What Country?<br>USA  |  |  |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 10th College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Laborer                                  |  | 16b. Kind of Business/Industry<br>Factory Worker   |   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Shade Hardy  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Sudie Edward Hardy  |   |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Evelyn Wilkins Daughter   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6778 Statum Rd Preston Md 21655   |   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bethel Home Cemetery  |  | 20c. Date<br>7/15/97   |   | 20d. Location - City or Town, State<br>Hertford NC               |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>Stallings Funeral Home<br>307 S Church St Hertford NC 279044  |  |  |   |  |  |  |
|  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Sepsis<br>Due to (or as a consequence of):<br>b. Metastatic Lung Cancer<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  | Approximate Interval Between Onset and Death<br>48 hrs<br>30 Days  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Dehydration, Malnutrition<br>Hypercalcemia  |   |   |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input checked="" type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  |   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                       |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No    |  | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br> MD   |   | 29c. License number<br>D 47924                 |  | 29d. Date signed (Month, Day, Year)<br>7/10/97  |  |  |  |
| 30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)<br>Norman Thanne 10 Aurora Street Cambridge Md 21613  |   |   |   |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 21 1997   |   | 32. Registrar's Signature<br>  |   |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

U.S. Army 1944

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23728

## Certificate of Death

Reg. No.

Amended #4, R.C., S.C. 7/25/97

|   |  |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|---|--|---|---|--|--|--|--|--|---|------------------------------|-----------|----------------------------------|--|--------------------------------|-----------|----------------------------------|--|--|----------------------------------|-------|----------------------------------|--|-----------------------------------|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Wilmer Hall  |   |   |  | 2. Date of Death<br>Month Day Year<br>July 9, 1997   |  | 3. Time of Death<br>9:15 p.m.                                    |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 4a. Facility Name (If not institution, give street and number)<br>Doctor's Community Hospital  |   |   |  | 4b. City, Town, or Location of Death<br>Lanham   |  | 4c. County of Death<br>Prince George's                           |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| Funeral<br>Director   | 5. Social Security Number<br>458-28-9721   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>71 Yrs.   | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>June 12, 1926   |  | 9. Birthplace (State or Foreign Country)<br>Houston, Texas   |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | Usual Residence of Decedent  |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| To Be Completed by Funeral Director   | 10a. State<br>Texas  | 10b. County<br>Harris   | 10c. City, Town or Location<br>Houston  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 10e. Street and Number<br>13822 Lillja Road  |   |   | 10f. Zip Code<br>77037   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>School Principal                     |  |  | 16b. Kind of Business/Industry<br>Education  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 17. Father's Name (First, Middle, Last)<br>Samuel Tilden Hall  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Lena Marie Falkenberg   |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br>Doris Hall - Spouse  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13102 North Freeway, Houston, Texas 77060 |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Calvary Hill Cemetery   |  | Date<br>07/14/97   | 20c. Location - City or Town, State<br>Humble, Texas   |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 21. Signature of Funeral Service Licensee<br>Claudette L. Gasch  |   |   | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781                |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td>e. Acute Arrhythmia - Lethal</td> <td>Immediate</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b. Acute Myocardial Infarction</td> <td>Immediate</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td>c. Acute Coronary Artery Disease</td> <td>Years</td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>d. Acute Cardiopulmonary Collapse</td> <td>Immediate</td> </tr> </table> |   |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death) | e. Acute Arrhythmia - Lethal | Immediate | Due to (or as a consequence of): |  | b. Acute Myocardial Infarction | Immediate | Due to (or as a consequence of): |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | c. Acute Coronary Artery Disease | Years | Due to (or as a consequence of): |  | d. Acute Cardiopulmonary Collapse |
| Immediate Cause (Final disease or condition resulting in death)   | e. Acute Arrhythmia - Lethal   | Immediate   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | b. Acute Myocardial Infarction   | Immediate   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | c. Acute Coronary Artery Disease   | Years   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   | Due to (or as a consequence of):   |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| d. Acute Cardiopulmonary Collapse   | Immediate  |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   | 28b. Time of Injury<br>M  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  | 28d. Describe how injury occurred  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| 29b. Signature and title of certifier<br>Jeffrey J. Hong MD   |  |   |   | 29c. License number<br>D33983  |  | 29d. Date signed (Month, Day, Year)<br>7/17/97   |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Jeffrey J. Hong, M.D. 575 Main Street, Suite 355, Laurel, Maryland 20707  |  |   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |
| 31. Date filed (Month, Day, Year)<br>JUL 22 1997  |  | 32. Registrar's Signature<br>John Andrew Raskol   |   |  |  |  |  |  |   |                              |           |                                  |  |                                |           |                                  |  |  |                                  |       |                                  |  |                                   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

to the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23729

Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |  |
|---|---|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>CLARA HANLEY</b>   |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>15</b> Year <b>97</b>   |  | 3. Time of Death<br><b>10:30 p</b>                                      |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SHOCK TRAUMA CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>BALTIMORE CITY</b>                            |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>227.28.8558</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>01.14.1921</b>                | 9. Birthplace (State or Foreign Country)<br><b>USA</b>   |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   | 10b. County<br><b>Prince George's</b>  | 10c. City, Town or Location<br><b>Temple Hills</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |  |
|   | 10e. Street and Number<br><b>5403 Winston St.</b>   |  |   | 10f. Zip Code<br><b>20748</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>                           |  |  | 16b. Kind of Business/Industry<br><b>Private</b>   |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Harry Dillard</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Pearl English</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Earnest Hanley / son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5403 Winston St. Temple Hills, MD 20748</b>  |  |   |  |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Restlawn Memorial Gardens</b>  |  | 20c. Location - City or Town, State<br><b>Bluefield, W. Va.</b>  |  | 20d. Date<br><b>7-23-97</b>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Juawana D. Braxton</b>  |  |   |  | 22. Name and Address of Facility<br><b>Marshall's of Md 4308 Sutherland Rd Sutherland, MD 20746</b>  |  |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>SEPSIS</b><br><br>Due to (or as a consequence of):<br><b>ISCHEMIA LEFT LEG</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |  |  |   | Approximate Interval Between Onset and Death<br><b>2 DAYS</b>  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) |   |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   | 28d. Describe how injury occurred  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |  |  |
| 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br><b>George M. Testerman</b>   |   |  |   | 29c. License number<br><b>051501</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 15 1997</b>                                     |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>George Testerman Dept of Surgery 22 South Green St. Baltimore, Md 21201</b>  |   |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>   |   | 32. Registrar's Signature<br><b>John Anderson-Randall</b>  |   |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23730

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |  |  |   |  |
|---|---|--|---|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>OZELL HARDEN</b>   |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>18</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:12AM</b>   |  |  |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Prince Georges Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Cheverly,</b>  |  | 4c. County of Death<br><b>Prince Georges</b>  |  |  |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-30-9608</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.                   | 8. Date of Birth (Month, Day, Year)<br><b>Feb 15, 1905</b>                                  |  | 9. Birthplace (State or Foreign Country)<br><b>Greenwood Co, SC</b>  |  |   |  |
|   | Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |   |  |
| To Be Completed by Funeral Director                                       | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>Mt. Ranier</b>  |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |   |  |
|   | 10e. Street and Number<br><b>4230 34th St. Apt. # 302</b>   |  |   |  | 10f. Zip Code<br><b>20712-0366</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>African-American</b>          |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>  |  |   | 16b. Kind of Business/Industry<br><b>Private</b> |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner                             | 17. Father's Name (First, Middle, Last)<br><b>Henry Terry</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Patsie Jones</b>  |  |   |  |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Jacqueline H. Mitchell</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3005 Metronome Turn, Clinton, MD 20735</b>  |  |   |  |  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Forest Hills Cemetery</b>  |  | Data<br><b>7-26-97</b>  |  | 20c. Location - City or Town, State<br><b>Clinton, MD</b>                                   |  |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Strickland Funeral Services, P.A.<br/>6500 Allentown Road, Camp Springs, MD 20748</b>  |  |   |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Malignant Hypertension</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   |   |  |   |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   |   |  |   |  |   |  |   |  |  |  |   |  |
| Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020 | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |   |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>030318</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/18/97</b>                                       |  |  |  |   |  |
| State Registrar   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)  |  |   |  |   |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>   |  |   |  |   |  |   |  | 32. Registrar's Signature<br>  |  |   |  |



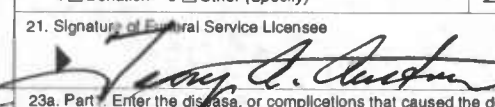
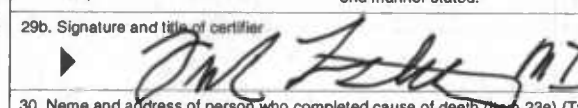
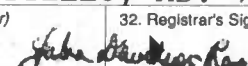
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State of Maryland / Department of Health and Mental Hygiene

97 23731

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |   |  |  |
|--|---|---|--|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>LOLLIE HUBBARD</b>                                   |   |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 11, 1997</b> |  | 3. Time of Death<br><b>4:48PM</b>                        |   |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>CLINTON</b>     |  | 4c. County of Death<br><b>P.G.</b>                       |   |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>577-42-3843</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>12-23-1931</b> |   |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>N.C.</b>   |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>PG</b>                                   |  | 10c. City, Town or Location<br><b>FORT WASHINGTON</b>    |   |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>7109 PLEASANT HILL DRIVE</b>  |  | 10f. Zip Code<br><b>20744</b>  |  | 10g. Citizen of What Country?<br><b>USA</b> |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH</b><br>College (14 or 5+) <b>ADMINSTRATOR</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>WHITE HOUSE</b>   |  | 16b. Kind of Business/Industry<br><b>WHITE HOUSE</b>   |  |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>LEVI ENOCH</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HATTIE MARTIN</b>  |  |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES J. HUBBARD</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7109 PLEASANT HILL DR. FT. WASH, MD. 20744</b>   |  |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ENOCH FAMILY CEMETERY</b>  |  | 20c. Location - City or Town, State<br><b>7/19/97 BURLINGTON, NC.</b>  |  |  |  |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>AUSTIN ROYSTER FUNERAL HOME</b><br><b>3821 14TH STREET N.W., WASH, D.C. 20011</b>   |  |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>GASTRIC CANCER</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |  |  |   | Approximate Interval Between Onset and Death   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |   |   |  |  |  |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |   |  |  |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred           |  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |  |
| 29a. Certifier<br>(Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |  |  |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br><b>027330</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 19, 1997</b>                      |  |   |  |  |
| 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><b>FRANK LISTELLO, MD. 7503 SURRATTS ROAD, CLINTON, MARYLAND</b>   |   |   |  |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>  |   | 32. Registrar's Signature<br>  |  |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23732

Reg. No.

|   |  |                               |   |                     |  |                     |  |  |
|---|--|-------------------------------|---|---------------------|--|---------------------|--|--|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>Gertrude deBruyn Hudson</b>   |                               |   |                     | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>1997</b>   |                     | 3. Time of Death<br><b>12:05am</b>   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>   |                               |   |                     | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |                     | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>224-09-8272</b>  |                               | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                     | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs.   |                     | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 26, 1913</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |                               | 10a. State<br><b>MD</b>   |                     | 10b. County<br><b>Montgomery</b>   |                     | 10c. City, Town or Location<br><b>Silver Spring</b>  |  |
| To Be Completed by<br>Funeral Director                  | Usual Residence of Decedent  |                               | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                     | 10e. Street and Number<br><b>1608 Forest Glen Road</b>   |                     | 10f. Zip Code<br><b>20910</b>  |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>  |                               | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |                     | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |                     | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |  |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |                               | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |                     | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Food Manager</b>   |                     | 16b. Kind of Business/Industry<br><b>Retail</b>  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Cornelius deBruyn</b>  |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Alberta Courtwright</b>  |                     | 19a. Informant's Name/Relationship (Type, Print)<br><b>Barbara J. Hudson</b>   |                     | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1608 Forest Glen Road, Silver Spring, MD 20910</b>   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |                               | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |                     | 20c. Location - City or Town, State<br><b>7/24/97 Silver Spring, MD</b>  |                     | 21. Signature of Funeral Service Licensee<br>  |  |
|   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>   |                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>a. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>c. <b>DIABETES MELLITUS</b><br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>YEARS</b><br><b>YEARS</b><br><b>YEARS</b> |                     | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                     |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                               | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                     | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |                               | 28a. Date of Injury (Month, Day, Year)  |                     | 28b. Time of Injury<br><b>M</b>  |                     | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|   | 28d. Describe how Injury occurred  |                               | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |                     | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                     | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
|   | 29b. Signature and title of certifier<br>  |                               | 29c. License number<br><b>D 36046</b>   |                     | 29d. Date signed (Month, Day, Year)<br><b>July 22, 1997</b>  |                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John J. Merendino Jr. 4701 Randolph Rd #216 Rockville Md. 20852</b>   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b> |  | 32. Registrar's Signature<br> |   | 33. State Registrar |  | 34. State Registrar |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner





|   |  |   |   |  |   |   |  |  |
|---|--|---|---|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Mohamed Wafik Hosny</b>   |   |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>21</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>1:45PM</b>                            |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>4701 WILLARD AVENUE</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>CHEVY CHASE</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-13-5082</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                      |  | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br><b>March 24, 1934</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Egypt</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Chevy Chase</b>            |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent  |   |   |  | 10f. Zip Code<br><b>20815</b>   |   | 10g. Citizen of What Country?<br><b>Egypt</b>                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> Collage (1-4 or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>alternate executive director</b>  |   | 16b. Kind of Business/Industry<br><b>World Bank</b>          |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Fouad Hosny</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hamida Toutouni</b>   |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Kawser Hosny/wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4701 Willard Ave., #807, Chevy Chase, Md. 20815</b>   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cairo Cemetery</b> |  | 20c. Location - City or Town, State<br><b>Cairo, Egypt</b>  |   | 20d. Date<br><b>July 26, 97</b>                              |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |   |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>2222 Wisconsin Ave., N.W., Wash., DC 20007</b>  |   |  |  |
|   | 23a. Pertinent, enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>AMBIEN INTOXICATION</b><br><i>[Signature]</i><br>Due to (or as a consequence of): |   |   |  | Approximate Interval Between Onset and Death  |   |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |   |   |  |   |   |  |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>found 7/21/97</b>   |   | 28b. Time of Injury<br><b>found 1:35 PM</b>                |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred<br><b>subject ingested pills</b>  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>4701 Willard Avenue 803, Chevy Chase, Maryland</b> |   |  |   |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |   |  |  |
| 29b. Signature and title of certifier<br><i>Theodore H. King</i>  |  |   |   | 29c. License number<br><b>O.C.M.E.</b>                     |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 23, 1997</b>                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THEODORE H. KING</b><br><b>111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>   |  |   |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i> |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23734**  
Certificate of Death

Reg. No.

|  |   |   |   |   |   |  |  |  |
|--|---|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>GAYLE CORBIN HARRISON</b>  |   |   |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>22</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1:00 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>197-24-6690</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 21, 1936</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Pennsylvania</b>   |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Gaithersburg</b>   |  |
| To Be Completed by<br>Funeral Director   | Usual Residence of Decedent   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>76 W. Deer Park Road, #103</b>   |  | 10f. Zip Code<br><b>20877</b>  |  |
|  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   | 11. Marital Status<br><input type="checkbox"/> Navar Mamiad <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>1954-</b><br>If Yes, Give Year or Dates: <b>1957</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> Collage (1-4 or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Accountant</b>  |  | 16b. Kind of Business/Industry<br><b>Medical</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Herbert Leslie Harrison</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Wava Corbin</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Wava Harrison, Mother</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>76 W. Deer Park Rd., #103, Gaithersburg, MD 20877</b>                                    |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |   | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>  |  | 20d. Date<br><b>July 24 1997</b>   |  |
|  | 21. Signature of Funeral Service Licensed<br><i>[Signature]</i>   |   | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 E. Deer Park Drive, Gaithersburg, MD 20877</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>SEPSIS</b><br><b>Pneumonia</b>                            |  | Approximate Interval Between Onset and Death<br><b>&lt;24 H.</b><br><b>&lt;24 H.</b>   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown                                      |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)<br><b>7-23-97</b>   |  |
|  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Physician <input type="checkbox"/> Medical Examiner  |   | 29b. Signature and Title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>035225</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7-23-97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Marion Boccardo, MD 12012 Venus Road Wheaton MD</b> |   | 31. Data filed (Month, Day, Year)<br><b>JUL 25 1997</b> |   | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23735

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Nick Steven Harris

2. Date of Death

Month Day Year  
July 22, 1997

3. Time of Death

8:45pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

218-56-8429

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

47 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 4, 1950

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10a. Street and Number

809 Whittington Terrace

10f. Zip Code

20901

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Assistant Distributor

16b. Kind of Business/Industry

Newspaper

17. Father's Name (First, Middle, Last)

Pete N. Harris

18. Mother's Name (First, Middle, Maiden Surname)

Jayne Mitchell

19a. Informant's Name/Relationship (Type, Print)

Jayne Harris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

809 Whittington Terrace Silver Spring, Maryland 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/25/97 Silver Spring, Maryland

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc.

500 University Blvd., W., Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Anoxic encephalopathy

Due to (or as a consequence of):

b.

Hypovolumic Shock

Due to (or as a consequence of):

c.

Gastrointestinal bleed

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

3 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D43496

29d. Date signed (Month, Day, Year)

July 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammad A Khalid MD. 8830 Cameron St. Silver Spring Md. 20910

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

20



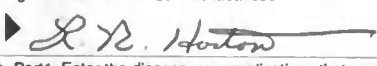

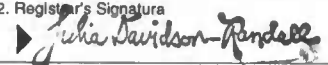
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23736

Reg. No.

|  |   |  |   |   |  |   |  |  |
|--|---|--|---|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JETTIE MAE HARRIS</b>  |  |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>18</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>00:05</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Washington Adventist Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Takoma</b>  |   | 4c. County of Death<br><b>Montgomery</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>457-54-8599</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Sep. 29, 1936</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Louisiana</b>  |  | 10e. State<br><b>DC</b>   |   | 10b. County<br><b>Washington</b>   |   | 10c. City, Town or Location<br><b>Washington</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>105 Missouri Avenue, N. W. #3</b>  |   | 10f. Zip Code<br><b>20011</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Waitress</b>  |   | 16b. Kind of Business/Industry<br><b>Private Industry</b>  |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>William Anthony</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Gertrude</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Donna Nwangwu/Daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>220 Hamilton Street, N.W., Wash., DC 20011</b> |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Glenwood Cemetery</b>  |   | Date<br><b>7/23/97</b>   |   | 20c. Location - City or Town, State<br><b>Washington, DC</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>R. N. Horton Co. Morticians, Inc.<br/>600 Kennedy Street, N. W., DC, 20011</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. acute myocardial infarction</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |   | Approximate Interval Between Onset and Death<br><b>50 mins</b>   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown                                      |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28e. Date of Injury (Month, Day, Year)   |  |
|  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>                       |  |
| 29c. License number<br><b>208546</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>July 18 1997</b> |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>John Tauber 8218 Wisconsin Ave Bethesda MD</b> |  | 31. Date filed (Month, Day, Year)<br><b>JUL 21 1997</b> |  |  |
| 32. Registrar's Signature<br> |   |  |   |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23737

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORIS HARDEN

2. Date of Death

Month Day Year  
July 21, 1997

3. Time of Death

11:55 PM

4a. Facility Name (If not institution, give street and number)

Northwest Hospital Center

4b. City, Town, or Location of Death

Randallstown

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

220-46-4887

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

96 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 14, 1901

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Sykesville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

7200 Third Avenue

10f. Zip Code

21784

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

Clerical

17. Father's Name (First, Middle, Last)

Benjamin Woodward Hazell

18. Mother's Name (First, Middle, Maiden Surname)

Mary Agnes Hoffnagle

19a. Informant's Name/Relationship (Type, Print)

Mrs. Jean English (Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

C-15 7200 Third Avenue Sykesville, MD 21784

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Carroll Cremation Serv 7/23/97

Date

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

Brian L. Haight

22. Name and Address of Facility

HAIGHT FUNERAL HOME & CHAPEL (Box 195)  
Sykesville, MD 21784 (410)-795-1400

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. RIGHT LOBE PNEUMONIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. SEPSIS

Due to (or as a consequence of):

30 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Joginder P Mehta M.D.

29c. License number

041410

29d. Date signed (Month, Day, Year)

July 21st, 1997.

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

JOGINDER P MEHTA NORTHWEST HOSPITAL CENTER RANDALLSTOWN.

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23738

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOYCE LINDA HILL

2. Date of Death

JUNE 26<sup>th</sup> 1997

3. Time of Death

6:07 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary

5. Social Security Number

264-68-5501

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Sept 19, 1944

9. Birthplace (State or Foreign Country)

Florida

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary

10c. City, Town or Location

Chaptico

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23696 John Walter Lane

10f. Zip Code

20621

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No -

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.  
Specify: White15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Clerical

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

James Arthur Edge

18. Mother's Name (First, Middle, Maiden Surname)

Berla Ann Huckabee

19a. Informant's Name/Relationship (Type, Print)

Joseph Walter Hill, Sr/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

23696 John Walter Lane, Chaptico, MD 20621

20a. Method of Disposition

X ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Charles Memorial Gardens

Date

6/30/97

20c. Location - City or Town, State

Leonardtown, MD

21. Signature of Funeral Service Licensee

Michael L. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, MD 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Probable Myocardial Infarction

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

See

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- COPD

- Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No

25. Was case referred to medical

X ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Boyd, II, MD

29c. License number

D14285

29d. Date signed (Month, Day, Year)

6-27-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Boyd, II, MD

Leonardtown, MD 20650

State  
Registrar

31. Date filed (Month, Day, Year)

JUL -4 1997

32. Registrar's Signature

J. L. Davidson-Randall

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23739

Reg. No.

|   |  |   |   |   |  |  |   |  |
|---|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Archie Walter Herbert</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>July 6, 1997</b>  |  | 3. Time of Death<br><b>4:55 PM</b>                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>38370 Golden Beach Road</b>   |   |   |   | 4b. City, Town, or Location of Death<br><b>Mechanicsville</b>  |  | 4c. County of Death<br><b>St. Mary's</b>                                |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-10-6744</b>  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>October 21, 1914</b>          |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>St. Mary's</b>   |  | 10c. City, Town or Location<br><b>Mechanicsville</b>                    |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>38370 Golden Beach Road</b>  |   | 10f. Zip Code<br><b>20659</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>                         |   | 16b. Kind of Business/Industry<br><b>Building</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Archie Holland Herbert</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret V. Canter</b>   |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary M. Herbert, Wife</b>   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>38370 Golden Beach Road, Mechanicsville, MD 20659</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |   | Date<br><b>7/8/97</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>      |  |
|   | 21. Signature of Funeral Service Licensee<br><br><b>Michael K. Blankenship</b>   |   |   |   | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>a. <b>Metastatic carcinoma of bile duct</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Cardiorespiratory failure</b><br/>Due to (or as a consequence of):</p> <p>c. _____<br/>Due to (or as a consequence of):</p> <p>d. _____<br/>Due to (or as a consequence of):</p> </div> <div style="width: 15%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>2 Months</b></p> <p><b>2 Months</b></p> </div> </div> |   |   |   |  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |   |   |  |  |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
|   |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |   |  |  |   |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br><b>D15369</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/7/97</b>                                 |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Umed Shah, M.D. 24035 Three Notch Road, Hollywood, Maryland 20636</b>  |  |   |   |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL - 9 1997</b>  |  | 32. Registrar's Signature<br>  |   |   |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23740

## Certificate of Death

Reg. No.

|                                     |  |  |   |  |  |  |   |  |  |  |
|-------------------------------------|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOAN ANNA HORN</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>20</b> Year <b>1997</b>   |  |   |  | 3. Time of Death<br><b>2:30 AM</b>   |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br><b>932 ROLLING RIDGE DR.</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>WESTMINSTER</b>   |  |   |  | 4c. County of Death<br><b>CARROLL</b>  |  |
| Funeral<br>Director                 | 5. Social Security Number<br><b>213-32-1502</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.   |  |
|                                     | 8. Date of Birth<br>(Month, Day, Year)<br><b>9/23/1935</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>CARROLL</b>   |  | 10c. City, Town or Location<br><b>WESTMINSTER</b>  |  |
| To Be Completed by Funeral Director | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>932 ROLLING RIDGE DR.</b>  |  | 10f. Zip Code<br><b>21157</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced |  |
|                                     | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TIME KEEPER</b>  |  |
|                                     | 16b. Kind of Business/Industry<br><b>HEALTH DEPARTMENT</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>PAUL GLEESSEN</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARZELLA KURTZENDORF</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>GEORGE J. HORN -HUSBAND</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>932 ROLLING RIDGE DR., WESTMINSTER, MD. 21157</b>                          |  |
|                                     | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>EVERGREEN MEM. GARDENS</b>   |  | Date<br><b>7/23/97</b>   |  | 20c. Location - City or Town, State<br><b>FINKSBURG, MD.</b>  |  | 21. Signature of Funeral Service Licensee<br>  |  |
|                                     | 22. Name and Address of Facility<br><b>FLETCHER FUNERAL HOME</b><br><b>254 E. MAIN ST., WESTMINSTER, MD. 21157</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Breast CA</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  | Approximate Interval Between Onset and Death   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|                                     | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)  |  |
|                                     | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|                                     | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D38915</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/21/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FREIST 295 Flower Ave Westminster 21157</b>   |  |
|                                     | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |  | 32. Registrar's Signature<br>   |  | 33. Registrar's Name<br><b>John Andrew Randall</b>   |  | 34. Registrar's Title<br><b>21157</b>   |  | 35. Registrar's Address<br><b>21157</b>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





97 23741

## Reg. No.

DMMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23742

|  |   |   |   |  |  |   |  |   |
|--|---|---|---|--|--|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedant's Name (First, Middle, Last)<br>Felizia S. Hohenner   |   |   |  | 2. Date of Death<br>Month Day Year<br>July 18 1997   |   | 3. Time of Death<br>0110   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br>University of Maryland Shock Trauma   |   |   |  | 4b. City, Town, or Location of Death<br>Baltimore  |   | 4c. County of Death<br>None  |   |
| Funeral<br>Director  | 5. Social Security Number<br>218-68-0475  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>79 Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br>Jan 21, 1918  | 9. Birthplace (State or Foreign Country)<br>Germany |
|  | Usual Residence of Decedant   |   |   |  |  |   |  |   |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland  |   | 10b. County<br>Howard   |  | 10c. City, Town or Location<br>Ellicott City   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |   |
|  | 10e. Street and Number<br>4053 St. John's Lane  |   |   |  | 10f. Zip Code<br>21042   |   | 10g. Citizen of What Country?<br>United States   |   |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedant Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
|  | 15. Decedant's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>2   |   |   |  | 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Volunteer   |   | 16b. Kind of Business/Industry<br>Florence Bain Center   |   |
|  | 17. Father's Name (First, Middle, Last)<br>Gustav Schoenemann   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Minna Charlotte Rottger   |   |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Hans Wolfgang Hohenner/Son  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>4053 St. Johns Lane Ellicott City, MD 21042   |   |  |   |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Balt-Washington Crematory   |  | 20c. Location - City or Town, State<br>7-21-97 Laurel, Maryland  |   |  |   |
|  | 21. Signature of Funeral Service Licensee<br>Shirley A. Collins - Witzke  |   |   |  | 22. Name and Address of Facility<br>Harry H. Witzke's Family Funeral Home, Inc.<br>4112 Old Columbia Pike Ellicott City, MD 21043  |   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. Cerebral Edema<br>Due to (or as a consequence of):<br><br>b. Subdural Hematoma<br>Due to (or as a consequence of):<br><br>c. Respiratory Insufficiency<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Motor Vehicle Accident  |   |   |  |  |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |   |   |   |  |  |   |  |   |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |   |  |  |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |   |  |  |   |  |   |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of injury (Month, Day, Year)<br>7/10/97   |   | 28b. Time of injury<br>1700 M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |
|  |   | 28d. Describe how injury occurred<br>Driver of car hit tree   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)<br>4344 Columbia Rd Ellicott City |  |   |  |   |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>David Hunter   |   | 29c. License number<br>7301  |  | 29d. Date signed (Month, Day, Year)<br>July 18, 1997  |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>David Hunter University of Maryland Shock Trauma Baltimore, MD 21201   |   |   |   |  |  |   |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 22 1997   |   | 32. Registrar's Signature<br>John Andrew Radell   |   |  |  |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23743

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LATTON IVerson

2. Date of Death

Month  
JulyDay  
21Year  
1997

3. Time of Death

5:35p.m.

4a. Facility Name (If not institution, give street and number)

Harford Memorial Hospital

4b. City, Town, or Location of Death

Havre de Grace

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

470-16-8605

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

June 10, 1921

9. Birthplace (State or Foreign Country)

Minnesota

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

528 S. Stepney Road

10f. Zip Code

21001

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: 1938-59

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

Collage (1-4or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Military

16b. Kind of Business/Industry

U.S. Army

17. Father's Name (First, Middle, Last)

Fred Iverson

18. Mother's Name (First, Middle, Maiden Surname)

Camilla Borgen

19a. Informant's Name/Relationship (Type, Print)

Michael W. Iverson (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1021 Old Phila. Rd., Aberdeen, MD 21001

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

R. A. Ferris &amp; Co., Inc.

Date

7/23/97

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Kenneth B. Cargo

22. Name and Address of Facility

Tarring-Cargo Funeral Home, P.A.

Aberdeen, Maryland 21001-3399

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. VENTRICULAR ARRYTHMIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Seconds

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

5 minutes

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular disease

Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Kenneth B. Cargo

29c. License number

1733088

29d. Date signed (Month, Day, Year)

7-23-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BETHANN BROWN, 1321 ALVONIA AVE SUITE 304 ABERDEEN, MD 21001

31. Date filed (Month, Day, Year)

JUL 23 1997

Registrar's Signature

John H. Hordell

State Registrar

LATTON NORMAN IVerson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

July 21, 1997 5:35pm

1041



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State of Maryland / Department of Health and Mental Hygiene

Amended # 19a, PG,GC,7/25/97

## Certificate of Death

Reg. No.

97 23744

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LaReintz Anthony Johnson

2. Date of Death

Month Day Year  
July 20, 1997

3. Time of Death

8:15AM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

6719 Vermont Ct.

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

5. Social Security Number

216-18-0629

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

74

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 9, 1922

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

6719 Vermont Ct.

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☒ Yes ☐ No  
If Yes, Give Year or Dates: 1940-54

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Minister

16b. Kind of Business/Industry

Church

17. Father's Name (First, Middle, Last)

Ralph Edward Johnson

18. Mother's Name (First, Middle, Maiden Surname)

Grace Darling Young

19a. Informant's Name/Relationship (Type, Print)

Maria Johnson (Wife, Daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6719 Vermont Ct., Hyattsville, Md. 20785

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arlington Crematory

Date

7-23

20c. Location - City or Town, State

Arlington Co., Va.

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Lewis Funeral Home

311 N. Patrick St., Alex., Va. 22314

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Prostate Cancer  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

Other:

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of Certifier

29c. License number

D20989

29d. Date signed (Month, Day, Year)

7/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6005 LANDOVER RD STE. 3 CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document is a list of names and addresses of the members of the committee.

2. The second part of the document is a list of names and addresses of the members of the committee.

3. The third part of the document is a list of names and addresses of the members of the committee.

4. The fourth part of the document is a list of names and addresses of the members of the committee.

5. The fifth part of the document is a list of names and addresses of the members of the committee.

6. The sixth part of the document is a list of names and addresses of the members of the committee.

7. The seventh part of the document is a list of names and addresses of the members of the committee.

8. The eighth part of the document is a list of names and addresses of the members of the committee.

9. The ninth part of the document is a list of names and addresses of the members of the committee.

10. The tenth part of the document is a list of names and addresses of the members of the committee.

11. The eleventh part of the document is a list of names and addresses of the members of the committee.

12. The twelfth part of the document is a list of names and addresses of the members of the committee.

13. The thirteenth part of the document is a list of names and addresses of the members of the committee.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23745

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
|--|--|---|--|---|--|--|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>John E. Joseph   |   |  |   | 2. Date of Death<br>Month July 7 Day 1997 Year   |  |   |  | 3. Time of Death<br>6:32 P.M.   |  |  |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>12701 Clearfield Drive   |   |  |   | 4b. City, Town, or Location of Death<br>Bowie  |  |   |  | 4c. County of Death<br>Prince George's  |  |  |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>173 26 2688   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |   | 7. Age (In yrs. last birthday)<br>65 Yrs.  |  | If Under 1 Year<br>Months Days  |  | If Under 24 Hrs.<br>Hours Min.  |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 12, 1931 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |  |
|  | Usual Residence of Decedent  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |   | 10b. County<br>Prince George's   |   | 10c. City, Town or Location<br>Bowie   |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No XX |  |  |  |  |  |
|  | 10e. Street and Number<br>12701 Clearfield Drive   |   |  |   | 10f. Zip Code<br>20715   |  |   |  | 10g. Citizen of What Country?<br>United States  |  |  |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 1956 |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                      |  |  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Engineer  |  |   |  | 16b. Kind of Business/Industry<br>Defense   |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Francis Joseph  |   |  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Margaret Mamelly                           |  |   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Ann E. Joseph Wife   |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12701 Clearfield Drive Bowie Maryland 20715   |  |   |  |   |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Sacred Heart Cemetery July 12, 1997 Bowie Maryland   |  |   |  | 20c. Location - City or Town, State   |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |  |   | 22. Name and Address of Facility<br>Robert E. Evans Funeral Home, Inc.<br>16000 Annapolis Rd. Bowie Md. 20715  |  |   |  |   |  |  |  |  |  |
|  | 23a. Permit the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |  |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death             |  |
|  | Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)<br>e. Cancer of unknown primary<br>Due to (or as a consequence of): |  |   |  |  |   |  |   |  |  |  |  |  |
| Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| b. Due to (or as a consequence of):  |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| c. Due to (or as a consequence of):  |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| d. Due to (or as a consequence of):  |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |   |  |  |   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No               |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |  |  |  |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |   |  |   |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |  |  |   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>  |   |  |   | 29c. License number<br>DC 20276  |  |   |  | 29d. Date signed (Month, Day, Year)<br>7/8/97   |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Claudine Isaacs MD 3800 Reservoir Rd Washington D.C.   |   |  |   |  |  |   |  |   |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>JUL 28 1997   |   |  |   | 32. Registrar's Signature<br>  |  |   |  |   |  |  |  |  |  |
|  | State Registrar  |   |  |   |  |  |   |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

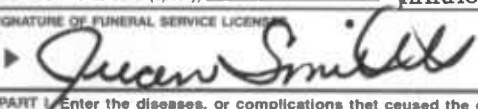
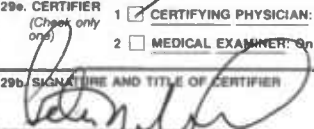

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



97 23746

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |   |                                |  |   |                                       |  |  |  |
|--|--|--|--|--|--|---|--------------------------------|--|---|---------------------------------------|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>DOROTHY THERESA JONES  |  |  |  | 2. DATE OF DEATH<br>MONTH 07 DAY 16 YEAR 97  |  |   |                                | 3. TIME OF DEATH<br>12:55 PM   |   |                                       |  |  |  |
| 4. SOCIAL SECURITY NUMBER<br>220-74-9065   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 6. AGE (In yrs. last birthday)<br>56 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS                     |   | IF UNDER 24 HRS.<br>HOURS MIN. |  | 7. DATE OF BIRTH (Month, Day, Year)<br>8/22/40  |                                       | 8. BIRTHPLACE (State or Foreign Country)<br>WASHINGTON, DC |  |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>SACRED HEART HOME, INC.  |  |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>HYATTSVILLE |   |                                |  |   | 9c. COUNTY OF DEATH<br>PRINCE GEORGES |  |  |  |
| RESIDENCE OF DECEDENT  |  |  |  |  |  |   |                                |  |   |                                       |  |  |  |
| 10a. STATE<br>MARYLAND   |  |  | 10b. COUNTY<br>PRINCE GEORGES  |  |  | 10c. CITY, TOWN OR LOCATION<br>HYATTSVILLE  |                                |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO |                                       |  |  |  |
| 10e. STREET AND NUMBER<br>5805 QUEENS CHAPEL ROAD  |  |  |  |  |  | 10f. ZIP CODE<br>20782  |                                |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                                       |  |  |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced<br>SINGLE  |  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |                                |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br>AFRO-AMERICAN                         |                                       |  |  |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (8-12) NONE College (1-4 or 5+) NONE  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>NONE  |  |   |                                | 16b. KIND OF BUSINESS/INDUSTRY<br>NONE   |   |                                       |  |  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>FRANK F. JONES SR.  |  |  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>MARGUERITE SIMMS   |                                |  |   |                                       |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>JEAN WOOD (SISTER)   |  |  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>12621 CAMBLETON DRIVE, LARGO, MD., 20774   |                                |  |   |                                       |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>HARMONY MEMORIAL PARK CEMETERY 7/21/97  |  |   |                                | 20c. LOCATION — City or Town, State<br>LANDOVER, MD.                                 |   |                                       |  |  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>  |  |  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>JOHN T. RHINES CO., INC.<br>3030 12TH ST NE, DC 20017   |                                |  |   |                                       |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Pneumonia<br>DUE TO (OR AS A CONSEQUENCE OF): Aspiration<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST<br>SENILE DEMENTIA<br>MENTAL RETARDATION |  |  |  |  |  |   |                                |  |   |                                       |  | Approximate Interval Between Onset and Death |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>SEIZURE DISORDER   |  |  |  |  |  |   |                                |  |   |                                       |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |   |                                |  |   |                                       |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |                                |  |   |                                       |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M  |                                | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   | 28d. DESCRIBE HOW INJURY OCCURRED     |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |                                |  |   |                                       |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |  |  |   |                                |  |   |                                       |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>   |  |  |  |  |  | 29c. LICENSE NUMBER<br>P22780   |                                |  | 29d. DATE SIGNED (Month, Day, Year)<br>7/18/97  |                                       |  |  |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>PETER M. SCHISLER, MD 7500 GREENWAY CTR DR., GREENBELT, MD., 20770  |  |  |  |  |  |   |                                |  |   |                                       |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 22 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br>   |  |   |                                |  |   |                                       |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23747

## Certificate of Death

Reg. No.

|   |   |   |   |                                |  |
|---|---|---|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                               | 1. Decedent's Name (First, Middle, Last)<br><b>Robert C. Jones, Jr.</b>   |   | 2. Date of Death<br>Month <b>July</b> Day <b>16</b> Year <b>1997</b>  |                                | 3. Time of Death<br><b>6:20 AM</b>   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |                                | 4c. County of Death<br><b>N/A</b>  |
| Funeral<br>Director   | 5. Social Security Number<br><b>071-42-8474</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 13, 1950</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |                                |  |
| To Be Completed by Funeral Director                             | Usual Residence of Decedent   |   | 10a. State<br><b>Maryland</b>   |                                |  |
|   | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Gaithersburg</b>  |                                |  |
|   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |                                |  |
|   | 10e. Street and Number<br><b>18932 Marsh Hawk Lane</b>  |   | 10f. Zip Code<br><b>20879</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |                                |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Nuclear Engineer</b>  |                                | 16b. Kind of Business/Industry<br><b>Government</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Robert C. Jones, Sr.</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Hart</b>  |                                |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Nancy K. Jones, Wife</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>18932 Marsh Hawk Lane, Gaithersburg, MD 20879</b>   |                                |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |                                | 20c. Location - City or Town, State<br><b>Silver Spring, MD</b>  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> |   | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive, Gaithersburg, MD 20877</b> |   |                                |  |
| Physician<br>/Medical<br>Examiner                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |   |   |                                | Approximate Interval Between Onset and Death<br><b>4 days</b><br><b>4 days</b>   |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>delerium, history of bone marrow transplant, lymphoma</b>  |   |   |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)<br><b>M</b>   |                                | 28b. Time of Injury<br><b>1</b> Yes <input type="checkbox"/> No  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |                                |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |   |   |                                |  |
|   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br><b>023887</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>July 16, 1997</b>  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Richard Ambinder, 418 N. Bond St., Johns Hopkins Oncology, Baltimore, MD</b>   |   |   |                                |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permt. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

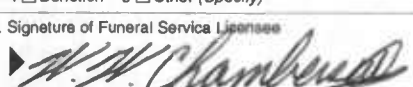
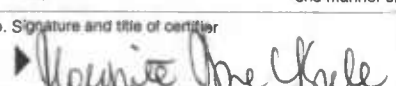
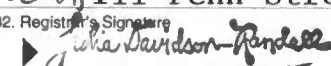
State of Maryland / Department of Health and Mental Hygiene

97 23748

MICHAEL N. JOHNSON

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |   |  |  |
|--|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL NEWTON JOHNSON</b>                    |   |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>22</b> Year <b>1997</b> |   | 3. Time of Death<br><b>2:30 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6304 GREENTREE ROAD</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>              |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-82-6607</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>28</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth<br>(Month, Day, Year)<br><b>SEPT. 26, 1968</b>                                | 9. Birthplace (State or Foreign Country)<br><b>JAMAICA</b>   |
|  | Usual Residence of Decedent  |   |  |  |  |   |  |  |
| 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>PRINCE GEORGES</b>  |  | 10c. City, Town or Location<br><b>BELTSVILLE</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>4309 BRIGGS CHANEY RD.</b>  |  |   |  | 10f. Zip Code<br><b>20705</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |  |
| 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   |  | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>CREW CHIEF</b>  |  | 16b. Kind of Business/Industry<br><b>W.S.S.C.</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>VINCENT JOHNSON</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>VILMA MOSELEY</b>  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>VINCENT JOHNSON/FATHER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>SAME AS ITEM #10</b>   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JOHNSON FAMILY PLOT</b>  |  | Date<br><b>7/31/97</b>   |  | 20c. Location - City or Town, State<br><b>JAMAICA ST. CATHERINE,</b>                        |  |  |
| 21. Signature of Funeral Service Licensee<br> <b>MD00091</b>   |  |   |  | 22. Name and Address of Facility<br><b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Drowning</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   |  | Approximate Interval Between Onset and Death   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>7 22 97</b>  |  | 28b. Time of Injury<br><b>1030 A M</b>   |  | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>FOUND IN DITCH, WATER MAINS BROKE</b>  |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>GREENTREE ROAD MONTGOMERY CO</b>  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 23, 1997</b>                                 |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARYANN B. KOSKOWSKI 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

TW

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23749

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Ramjit Jagrup</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>July 22, 1997</b>  |  | 3. Time of Death<br><b>3:32pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>27 County Court</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Gaithersburg</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>077-76-7614</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>45</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 13, 1952</b>                                 |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Guyana</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Gaithersburg</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>27 County Court</b>  |  | 10f. Zip Code<br><b>20878</b>   |  | 10g. Citizen of What Country?<br><b>Guyana</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify:<br><b>West Indian</b>            |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Automotive Technician</b>   |  | 16b. Kind of Business/Industry<br><b>Automotive</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>"UNKNOWN" JAGRUP</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>"UNKNOWN" ROOKMATIE</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Agnes Jagrup (Wife)</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27 County Court, Gaithersburg, MD 20878</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | 20c. Date<br><b>7/25/1997</b>   |  |
|   | 20d. Location - City or Town, State<br><b>Silver Spring, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><b>Michael D. Gibbons</b>  |  | 22. Name and Address of Facility<br><b>DeVol Funeral Home</b><br><b>10 East Deer Park Drive</b><br><b>Gaithersburg, MD 20877</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Carcinoma of Colon</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>4 years</b>  |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  | 29b. Signature and title of certifier<br><b>Jeremy V. Cooke</b>   |  | 29c. License number<br><b>D04602</b>  |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>7/23/97</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Jeremy V. Cooke 10400 Conn. Ave. Kensington Md</b>   |  |   |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>   |  | 32. Registrar's Signature<br><b>John Davidson-Rendall</b>   |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23750

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |  |  |  |
|---|---|---|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>GEORGE CROUCH KENDALL   |   |   |   | 2. Date of Death<br>Month Day Year<br>JULY 10, 1997  |  | 3. Time of Death<br>2:00 P.M.  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>5763 Kent Avenue (At Home)  |   |   |   | 4b. City, Town, or Location of Death<br>Rock Hall  |  | 4c. County of Death<br>Kent  |  |
| Funeral<br>Director   | 5. Social Security Number<br>218-16-6977  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>74 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>July 14, 1922   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |   |   |   |  |  |  |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |   |  |  |  |  |
|   | 10a. State<br>Maryland  |   | 10b. County<br>Kent   |   | 10c. City, Town or Location<br>Rock Hall   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br>5763 Kent Avenue  |   |   |   | 10f. Zip Code<br>21661   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>8   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Waterman  |  | 16b. Kind of Business/Industry<br>Seafood  |  |
|   | 17. Father's Name (First, Middle, Last)<br>George Elmer Kendall   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Violet Marguire Crouch  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Ruth Alice Kendall/Wife   |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5763 Kent Avenue, Rock Hall, Maryland 21661   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Wesley Cemetery/July 13, 1997   |   | 20c. Location - City or Town, State<br>Rock Hall, Maryland   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |   | 22. Name and Address of Facility<br>Fellows, Helfenbein & Newnam Funeral Home, P.A.<br>130 Speer Road, Chestertown, Maryland 21620   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cirrhosis of liver</i><br>Due to (or as a consequence of):<br>b. <i>alcoholism</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   | Approximate Interval Between Onset and Death<br><i>many years</i>  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |
|   |   |   |   |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |
|   |   |   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M                  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |
|   |   | 28d. Describe how injury occurred   |   |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |   | 29c. License number<br>D21313             |  | 29d. Date signed (Month, Day, Year)<br>7/11/97   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>KIN K. WUN, 223 High St., Chestertown, MD 21620   |   |   |   |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 '97   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23751

## Certificate of Death

Reg. No.

|   |  |   |  |  |  |  |  |  |  |  |
|---|--|---|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Oswald</i>  |   |  |  | 2. Date of Death<br>Month <i>July</i> Day <i>18</i> Year <i>1997</i> |  |  |  | 3. Time of Death<br><i>11:20pm</i>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Southern Maryland Hospital Center</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Prince Georges</i>        |  |  |  | 4c. County of Death<br><i>Prince Georges</i>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>243-38-6584</i>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><i>68</i>                          |  | 8. Date of Birth (Month, Day, Year)<br><i>Sept. 28, 1928</i> |  | 9. Birthplace (State or Foreign Country)<br><i>Bluntee Creek N.C.</i>                          |  |
|   | 10a. State<br><i>MD</i>  |   | 10b. County<br><i>P.G.</i>   |  | 10c. City, Town or Location<br><i>District Heights</i>               |  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><i>2516 Roslyn Ave.</i>   |  | 10f. Zip Code<br><i>20743</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  |  | 14. Race - American Indian, Black, White, etc.<br><i>Black</i> |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><i>3</i>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Landscaper</i>  |  | 16b. Kind of Business/Industry<br><i>Government</i>  |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>Tiney Keys</i>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Josephine Minor</i>  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Ellen Keys</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2516 Roslyn Ave, Dist. Hgts. Md. 20743</i>   |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Harmony Mem. Cemetery</i>  |  | 20c. Location - City or Town, State<br><i>7/26/97 Landover, Md.</i>  |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Prince Edwards</i>  |  | 22. Name and Address of Facility<br><i>Hodges and Edwards</i><br><i>3910 Silver Hill Rd. Suitland, Md.</i>  |  |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><i>Acute Respiratory failure</i><br><i>status asthmaticus</i><br><i>CAD</i><br><i>Cardiophrenic</i>  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><i>12W</i>   |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>DM, HTN, S/P MI</i>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |  |
|   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                              |  |  |
|   |  | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br><i>Dr. A. A. Hardy</i>   |  | 29c. License number<br><i>D24208</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>7-19-97</i>  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>ABULHASAN U ANSARI Clinton Md. 20731</i>   |  |   |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 22 1997</i>   |  | 32. Registrar's Signature<br><i>John Andrew Randall</i>   |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 23752

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|--|---|---|--|--|--|--|---|---|----|---------------------------------|--|----|--------------------------------|-----------------|----|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Charles Russell Kendall</b>                  |   |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>23</b> Year <b>1997</b> |  | 3. Time of Death<br><b>5:10 AM</b>                          |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1402 Leister Drive</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>         |  | 4c. County of Death<br><b>Montgomery</b>                    |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-24-7271</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 30, 1921</b> |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b>                           |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Montgomery</b>                                     |  | 10c. City, Town or Location<br><b>Silver Spring</b>         |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>1402 Leister Drive</b>   |  | 10f. Zip Code<br><b>20904</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1942-46</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>I</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Shipping Manager</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Charles H. Kendall</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Blanche Kirby</b>  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Craig Kendall</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>103 Hannes Street, Silver Spring, MD 20901</b>   |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Date<br><b>7/24/97</b>  |  | 20d. Location - City or Town, State<br><b>Alexandria, VA</b>   |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>   |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>Congestive Heart Failure</b></td> <td>Approximate Interval Between Onset and Death<br/><b>3 Years</b></td> </tr> <tr> <td>b.</td> <td><b>Coronary Artery Disease</b></td> <td><b>10 Years</b></td> </tr> <tr> <td>c.</td> <td></td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |   |   |  |  |  |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>Congestive Heart Failure</b> | Approximate Interval Between Onset and Death<br><b>3 Years</b> | b. | <b>Coronary Artery Disease</b> | <b>10 Years</b> | c. |  |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | a.  | <b>Congestive Heart Failure</b>   | Approximate Interval Between Onset and Death<br><b>3 Years</b>             |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  | b.  | <b>Coronary Artery Disease</b>  | <b>10 Years</b>  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  | c.  |   |  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  | d.  |   |  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Chronic Renal Failure</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   | 29b. Signature and Title of certifier<br>  |  | 29c. License number<br><b>D31563</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 23, 1997</b>  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Charles M. Benner, MD 11251 Lockwood Drive, Silver Spring, MD 20901</b>   |   |   |  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>  |   | 32. Registrar's Signature<br>  |  |  |  |  |   |   |    |                                 |  |    |                                |                 |    |  |  |    |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

12 + 1g.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23753

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ellis Nathan Kahn

2. Date of Death

Month Day Year  
July 20, 1997

3. Time of Death

5:45 AM

4a. Facility Name (If not institution, give street and number)

Hebrew Home of Greater Washington

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

153-09-4957

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

84

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 29, 1912

9. Birthplace (State or Foreign Country)

Pa.

Usual Residence of Decedent

10a. State

Md.

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

12009 Trailridge Dr.

10f. Zip Code

20854

10g. Citizen of What Country?

US

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give

Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Executive/self-employed

16b. Kind of Business/Industry

Wholesale Paper Co.

17. Father's Name (First, Middle, Last)

Harry Kahn

18. Mother's Name (First, Middle, Maiden Surname)

Goldie Shulman

19a. Informant's Name/Relationship (Type, Print)

Sara Hecht/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9412 Fox Hollow Dr. Potomac, Md. 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

King David Memorial Gardens 7/22/97 Falls Church, Va.

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Edward Sagel Funeral Direction  
1091 Rockville Pike Rockville, Md. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ALZHEIMERS DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 months

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ OOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Chelamos

29c. License number

D 33224

29d. Date signed (Month, Day, Year)

JULY 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R Treham MD 50 W Edmonston Dr Rockville MD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



97-4048-031

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

HELENA

State of Maryland / Department of Health and Mental Hygiene

KAPOW

Item: 4b per MEO G-750 8/20/97 dh  
Items: 23a part 1, 27, 28a-f per MEO G-750 8/11/97 dh

Certificate of Death

Reg. No.

97 23754

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Helena Casey Kadow

2. Date of Death  
Month Day Year

JULY 20 1997 10:45A.M

3. Time of Death

4e. Facility Name (If not institution, give street and number)

3307 W.COQUELIN TERRACE

4b. City, Town, or Location of Death

CHEVY CHASE  
BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

577-38-6299

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

Aug. 15, 1908

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Chevy Chase

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3307 West Coquelin Terrace

10f. Zip Code

20815

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Real Estate Broker

16b. Kind of Business/Industry

Real Estate

17. Father's Name (First, Middle, Last)

Timothy J. Casey

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Galvin

19a. Informant's Name/Relationship (Type, Print)

Brian A. Kadow

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3603 Thornapple Street, Chevy Chase, MD 20815

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/24/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

Steven D. Stinson

22. Name and Address of Facility  
Francis J. Collins Funeral Home, Inc. 500 University Blvd. West  
Silver Spring, MD 20901

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. HYPERTHERMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

DRIVEWAY

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

7/20/97 found

28b. Time of Injury

unknown

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unable to exit car

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

automobile

28f. Location (Street and Number or Rural Route Number, City or Town, State)

3307 W. Coquelin Terrace, Bethesda, Md.

29a. Certifier  
(Check only one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Stephen S. Radentz

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Podell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



97 23755

## Reg. No.

**Medical Certification: To Be Completed by Physician/Medical Examiner**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23756

Amended #26, 7/23/97, M.W.O., Howard Co.

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vera Kolankowski

2. Date of Death

Month Day Year  
July 18 1997

3. Time of Death

3:47 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Howard County General Hospital

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

5. Social Security Number

189-05-7166

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth

(Month, Day, Year)  
April 17, 1909

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Glenelg

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4093 Sharp Road

10f. Zip Code

21737

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Sales Representative

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Bruno Bernardoni

18. Mother's Name (First, Middle, Maiden Surname)

Felice Stafferoni

19a. Informant's Name/Relationship (Type, Print)

Patricia F. Kolly/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4093 Sharp Road Glenelg, Maryland 21737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Memorial Park

Date

7-21-97

20c. Location - City or Town, State

Marriottsville, MD

21. Signature of Funeral Service Licensee

Shirley A. Collins-Witzke

22. Name and Address of Facility

Harry H. Witzke's Family Funeral Home, Inc.  
4112 Old Columbia Pike Ellicott City, MD 21043

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cerebrovascular Accident

Due to (or as a consequence of):

b. Generalized Atherosclerosis

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Severe Ischemic Cardiomyopathy.

Chronic Renal Failure. Hypertension

Cerebrovascular Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Attending

29c. License number

D16200

29d. Date signed (Month, Day, Year)

JULY 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERTO M. MACHIRAN, M.D. 720 C MAIDEN CHOICE LA. BALTO. MD. 21228

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John M. Russell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23757

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |                                 |   |   |   |                                   |  |  |
|---|--|--|---|--|---|---------------------------------|---|---|---|-----------------------------------|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ARTHUR JACKSON LOCKWOOD</b>   |  |   |  |   |                                 | 2. Date of Death<br>Month <b>July</b> Day <b>15</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>1:40pm</b>                                   |                                   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Kent &amp; Queen Anne's Hospital</b>  |  |   |  |   |                                 | 4b. City, Town, or Location of Death<br><b>Chestertown</b>  |   | 4c. County of Death<br><b>Kent</b>                                  |                                   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>221-16-8664</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>69</b> Yrs.  |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 9 1927</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>         |                                   |  |  |
|   | Usual Residence of Decedent  |  |   |  |   |                                 | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Kent</b>  |                                   | 10c. City, Town or Location<br><b>Millington</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |                                 | 10e. Street and Number<br><b>30205 Morgnec Rd.</b>  |   | 10f. Zip Code<br><b>21651</b>                                       |                                   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1946</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |   |                                   |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mechanic</b>  |                                 |   |   | 16b. Kind of Business/Industry<br><b>Automobile Service Station</b> |                                   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John Thomas Lockwood</b>   |  |   |  |   |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Florence Darrel</b>   |   |   |                                   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Geraldine K. Lockwood (wife)</b>  |  |   |  |   |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>30205 Morgnec Rd. Millington, MD. 21651</b> |   |   |                                   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crumpton Cemetery</b>  |                                 | 20c. Location - City or Town, State<br><b>7-18-97 Crumpton, MD.</b>   |   |   |                                   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i> <b>MD0510</b>  |  |   |  | 22. Name and Address of Facility<br><b>Galena Funeral Home of Stephen Schaech<br/>Box 235 Galena, MD. 21635</b>   |                                 |   |   |   |                                   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. Aspiration pneumonia</b><br>Due to (or as a consequence of):<br><b>c. Congestive Heart Failure</b><br>Due to (or as a consequence of):<br><b>d.</b> |  |   |  |   |                                 |   |   |   |                                   | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ASCD, History CABG, History CABG with @ Hepatitis</b>   |  |   |  |   |                                 |   |   |   |                                   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                 |   |   |   |                                   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |   | 26a. Date of Injury (Month, Day, Year)<br><b>none</b>                        |   | 26b. Time of injury<br><b>M</b> |   | 26c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 26d. Describe how injury occurred |  |  |
| 28a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   | 28b. Location (Street and Number or Rural Route Number, City or Town, State) |   |                                 |   |   |   |                                   |  |  |
| 29a. Signature and title of certifier<br><i>[Signature]</i>   |  |  |   | 29c. License number<br><b>D23889</b>   |   |                                 |   | 29d. Date signed (Month, Day, Year)<br><b>7/17/97</b>                                       |   |                                   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John C. Arrabal Jr. MD. 948 Washington Ave. Chestertown, MD. 21620</b>   |  |  |   |  |   |                                 |   |   |   |                                   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 17 '97</b>  |  |  |   | 32. Registrar's Signature<br><i>[Signature]</i>                              |   |                                 |   |   |   |                                   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23758

Amended # 7. P.G.C. 8-4-97cr

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mae Leitma

2. Date of Death

Month Day Year  
July 22, 1997

3. Time of Death

5:00 AM

4a. Facility Name (If not institution, give street and number)

National Lutheran Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery Co.

5. Social Security Number

026-26-5800

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

87 97 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 9, 1900

9. Birthplace (State or Foreign Country)

Estonia

Usual Residence of Decedent

10a. State

Md.

10b. County

Washington Co.

10c. City, Town or Location

Hagerstown

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

21835- White Oak Rd.,

10f. Zip Code

21740

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married☒ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16e. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

At Home

17. Father's Name (First, Middle, Last)

Artu Pojo

18. Mother's Name (First, Middle, Maiden Surname)

Liisa Pojo

19e. Informant's Name/Relationship (Type, Print)

Gunnar Leitma (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

21835-White Oak Rd., Hagerstown, Md. 21740

20e. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Metropolitan Crematory-7/23

Date

20c. Location - City or Town, State

Alexandria, Va.

21. Signature of Funeral Service Licensee

W.M. Hysong

22. Name and Address of Facility

Hysong Co., Inc.

1300-N Street, NW, Wash., DC

23e. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

b.

Alzheimer's

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Approximate Interval Between Onset and Death

hours

years

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24e. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☐ Yes ☒ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☒ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Daniel Salla

29c. License number

D33138

29d. Date signed (Month, Day, Year)

July 22, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel Salla MD 12850 Middlebrook Rd. Germantown, MD

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

John Randolph

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23759

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marian Mae Langdon

2. Date of Death

Month Day Year  
July 17 1997

3. Time of Death

5:16 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

North Arundel Hospital

4b. City, Town, or Location of Death

Glen Burnie

4c. County of Death

Anne Arundel

5. Social Security Number

577 01 1058

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 30, 1908

9. Birthplace (State or Foreign Country)

Washington D.C.

Usual Residence of Decedent

10a. State  
Maryland10b. County  
Anne Arundel10c. City, Town or Location  
Crofton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2509 Chelmsford Drive

10f. Zip Code

21114

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Operator

16b. Kind of Business/Industry

C&amp;P Telephone

17. Father's Name (First, Middle, Last)

Alvin Allen Talbott

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Mae Blumer

19a. Informant's Name/Relationship (Type, Print)

Barbara Lee Langdon Granddaughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2509 Chelmsford Drive Crofton Maryland 21114

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

Date

July 22, 1997

20c. Location - City or Town, State

Arlington Virginia

21. Signature of Funeral Service Licensee

Michael D. Bigler

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Cardio pulmonary Arrest

Due to (or as a consequence of):

b. Unsepsis

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D 43977

29d. Date signed (Month, Day, Year)

July 17 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Cyprien ORETHANT, 301 HOSPITAL DRIVE, GLEN BURNIE, MD. 21061

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Shirley Anderson-Rucker

State Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(5)

Marian M Langdon



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23760

Reg. No.

|  |   |  |                                  |   |  |  |   |   |
|--|---|--|----------------------------------|---|--|--|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES LASSITER</b>                                   |  |                                  |   | 2. Date of Death<br>Month <b>July</b> Day <b>16</b> Year <b>1997</b> |  | 3. Time of Death<br><b>10 30pm</b>                    |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SOUTHERN MARYLAND HOSPITAL</b> |  |                                  |   | 4b. City, Town, or Location of Death<br><b>CLINTON</b>               |  | 4c. County of Death<br><b>PRINCE GEORGES</b>          |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>244-26-8925</b>   |  | 6. Sex<br><b>1 M 2 F</b>         | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.  | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>1/23/29</b> | 9. Birthplace (State or Foreign Country)<br><b>Smithfield, NC</b>             |
|  | 10a. State<br><b>DC</b>   |  | 10b. County<br><b>Washington</b> |   | 10c. City, Town or Location<br><b>Washington</b>                     |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>          |   |
| 10e. Street and Number<br><b>1433 Ridge Place SE</b>   |   | 10f. Zip Code<br><b>20020</b>  |                                  | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   |   |
| 11. Marital Status<br><b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1 Yes 2 No</b>   |                                  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 No Specify:</b>        |  | 14. Race - American Indian, Black, White, etc.<br><b>Specify: BLACK</b>                          |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>12</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>                     |                                  | 16b. Kind of Business/Industry<br><b>Trucking/Private</b>   |  |  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Ernest Lassiter</b>  |   |  |                                  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Sanders</b>   |  |  |   |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Ms. Betty Lassiter/Daughter</b>   |   |  |                                  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1433 Ridge Place SE, Washington, DC 20020</b> |  |  |   |   |
| 20a. Method of Disposition<br><b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Memorial Pk.</b>  |                                  | Date<br><b>7/23/97</b>  |  | 20c. Location - City or Town, State<br><b>Landover, Md.</b>                                      |   |   |
| 21. Signature of Funeral Service Licensee<br><b>Phillip Bell</b>   |   |  |                                  | 22. Name and Address of Facility<br><b>Robert G. Mason Funeral Home<br/>1661 Good Hope Rd. SE Washington, DC 20020</b>                            |  |  |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Intracerebral Haemorrhage</b><br>Due to (or as a consequence of):<br><b>b. Systemic Hypertension</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequitentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |                                  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>6 days-<br/>Many Years</b> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes Mellitus -<br/>Renal Insufficiency - Chronic.</b>  |   |  |                                  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 Unknown</b> |   |   |
| 24a. Was an autopsy performed?<br><b>1 Yes 2 No</b>  |   |  |                                  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1 Yes 2 No</b> |   |   |
| 25. Was case referred to medical examiner?<br><b>1 Yes 2 No</b>  |   | 28. Place of Death (Check only one)<br>Hospital: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |                                  |   |  |  |   |   |
| 27. Manner of Death<br><b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined</b>  |   | 28a. Date of Injury (Month, Day Year)  |                                  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |   | 28d. Describe how injury occurred   |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.</b>   |   | 29b. Signature and title of certifier<br><b>Gyan Chand Surana</b>  |                                  | 29c. License number<br><b>D0050653</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/18/97</b>  |   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GYAN CHAND SURANA 7501 Surratts Road Clinton M.D.</b>   |   |  |                                  |   |  |  |   |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |   | 32. Registrar's Signature<br><b>J. A. Anderson-Randall</b>   |                                  |   |  |  |   |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23761  
Certificate of Death

Reg. No.

|  |   |                           |   |   |   |  |   |  |  |   |  |
|--|---|---------------------------|---|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Florence Rothfeld Lipskind              |                           |   |   | 2. Date of Death<br>Month Day Year<br>July 21, 1997   |  | 3. Time of Death<br>5:55PM                              |  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>Suburban Hospital |                           |   |   | 4b. City, Town, or Location of Death<br>Bethesda  |  | 4c. County of Death<br>Montgomery                       |  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>089-12-5939  |                           | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>76 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>January 16, 1921 |  | 9. Birthplace (State or Foreign Country)<br>New York |   |  |
|  | Usual Residence of Decedent   |                           |   |   |   |  |   |  |  |   |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Montgomery |   | 10c. City, Town or Location<br>Silver Spring  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |
| 10e. Street and Number<br>2406 Lillian Dr.   |   |                           |   | 10f. Zip Code<br>20902  |   | 10g. Citizen of What Country?<br>United States |   |  |  |   |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   |                           | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |   |                           |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Owner  |   |  | 16b. Kind of Business/Industry<br>Jewelry Store         |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br>Herman Rothfeld   |   |                           |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Fannie Miller  |   |  |   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Marilyn Lipskind (Daughter)  |   |                           |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5809 Nicholson Ln. # 1108, Rockville, MD. 20852  |   |  |   |  |  |   |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   |                           |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>King David Mem. Gardens   |   | Date<br>7-24-97                                |   | 20c. Location - City or Town, State<br>Falls Church, Virginia                                  |  |   |  |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   |                           |   | 22. Name and Address of Facility<br>Danzansky-Goldberg Mem. Chapels, Inc.<br>1170 Rockville Pike, Rockville, MD. 20852  |   |  |   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Cerebral infarct</i><br>Due to (or as a consequence of):<br>b. <i>Carotid stenosis</i><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                           |   |   |   |  |   |  |  | Approximate Interval Between Onset and Death  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Hypertension</i>  |   |                           |   |   |   |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                           |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |                           |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |   |  |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |                           |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M                       |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No           |  | 28d. Describe how injury occurred   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |                           |   | 29b. Signature and Title of certifier<br><i>Elliot Wilner MD</i>  |   |  |   | 29c. License number<br>D.C. # 4259   |  | 29d. Date signed (Month, Day, Year)<br>July 21, 1997  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Elliot Wilner, 5454 Wisconsin Ave, Chevy Chase MD</i>   |   |                           |   |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1997   |   |                           |   | 32. Registrar's Signature<br><i>Julia Davidson-Rendell</i>  |   |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

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Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

EDWIN CHARLES LEWINSKI State of Maryland / Department of Health and Mental Hygiene

97 23762

Items: 23a part I, II, 27, 28a-f per ME0 G-750 8/11/97 dh Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edwin Charles Lewinski

2. Date of Death  
Month Day Year

JULY 18, 1997

3. Time of Death  
1630PMFuneral  
Director

4e. Facility Name (If not Institution, give street and number)

9924 WALKER HOUSE ROAD APT. #5

4b. City, Town, or Location of Death

GAITHERSBURG

4c. County of Death

MONTGOMERY

5. Social Security Number

213-58-0587

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

April 15, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

9924 Walker House Road Apt. #5

10f. Zip Code

20879

10g. Citizen of What Country?

United States

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Cable Splicer

16b. Kind of Business/Industry

Telephone

17. Father's Name (First, Middle, Last)

Edwin Lewinski

18. Mother's Name (First, Middle, Maiden Surname)

Julie Marie Vostrez

19a. Informant's Name/Relationship (Type, Print)

Edwin Lewinski (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5317 Crestedge Lane, Rockville, MD 20853

20a. Method of Disposition

☐ Burial ☒ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7/20/97

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Michael D. Hibbons

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Drive

Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE ETHANOL AND DIAZEPAM INTOXICATION

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CIRRHOSIS OF LIVER

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No25. Was case referred to medical examiner?  
☒ Yes ☐ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

Other:

☐ Nursing Home ☒ Residence ☐ Other (Specify)

27. Manner of Death

☐ Natural☐ Accident☐ Suicide☐ Homicide5 ☐ Pending investigation6 ☒ Could not be determined28a. Date of Injury  
(Month, Day, Year)

found 7/18/97

28b. Time of Injury

found 3:30M

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at home

28f. Location (Street and Number or Rural Route Number, City or Town, State)

9924 Walker House Rd.,

Apt. #5 Gaithersburg, MD.

29a. Certifier  
(Check only one)☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dennis J. Chute

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 20, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dennis J. Chute

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23763

## Certificate of Death

Reg. No.

|   |  |  |                               |   |  |  |  |  |  |
|---|--|--|-------------------------------|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>VIVIAN JEE</b>                                |  |                               |   | 2. Date of Death<br>Month Day Year<br><b>07-20-97</b>      |  | 3. Time of Death<br><b>9:45 AM</b>                     |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>LEGACY NURSING HOME</b> |  |                               |   | 4b. City, Town, or Location of Death<br><b>Forestville</b> |  | 4c. County of Death<br><b>Prince George's</b>          |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>129-18-6933</b>  |  | 6. Sex<br><b>1 M 2 F</b>      |   | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.           |  | 8. Date of Birth (Month, Day, Year)<br><b>11-15-12</b> |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>South Carolina</b>                            |  | 10a. State<br><b>Maryland</b> |   | 10b. County<br><b>Prince George's</b>                      |  | 10c. City, Town or Location<br><b>Mitchellville</b>    |  |  |
| Usual Residence of Decedent   |  | 10d. Inside City Limits<br><b>Yes</b> <input checked="" type="checkbox"/> <input type="checkbox"/> No  |                               | 10e. Street and Number<br><b>13905 Mt. Oak Court</b>  |  | 10f. Zip Code<br><b>20721</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><b>3 Widowed</b> <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced                                    |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>2 No</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                       |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>2 No</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br><b>Black</b> Specify:  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>                          |                               | 16b. Kind of Business/Industry<br><b>Government</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Charles Cantey</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Eloise Oden</b>  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Audrey Thomas/Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>13905 Mt. Oak Court, Mitchellville, MD 20721</b> |                               | 20a. Method of Disposition<br><b>3 Removal from State</b> <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Long Island National Cem.</b>   |  | 20c. Location - City or Town, State<br><b>7/25/97 Farmingdale, NY</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>Nancy A. Perentis</b>   |  | 22. Name and Address of Facility<br><b>J. B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, Maryland 20785</b>                               |                               | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Alzheimers Disease</b><br>Due to (or as a consequence of):<br><br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b><br><br><b>Due to (or as a consequence of):</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><b>2 No</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 3 Probably <input type="checkbox"/> 4 Unknown   |  | 24a. Was an autopsy performed?<br><b>2 No</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> 24b. Were autopsy findings available prior to completion of cause of death?<br><b>2 No</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroidism</b><br><b>Multiple Decubitus Ulcers</b> |  | 25. Was case referred to medical examiner?<br><b>2 No</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/>                           |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><b>1 Natural</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)<br><b>7/20/97</b>  |  |
| 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>2 No</b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/>   |                               | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
| 29a. Certifier (Check only one)<br><b>1 Certifying Physician</b> <input checked="" type="checkbox"/> <b>2 Medical Examiner</b> <input type="checkbox"/>                             |  | 29b. Signature and title of certifier<br><b>Lester M. Miles, M.D.</b>  |                               | 29c. License number<br><b>026024</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/20/97</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Lester M. Miles, M.D. 6490 Landover Road, Landover, Maryland 20785</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>   |  | 32. Registrar's Signature<br><b>John Andrew Randall</b>  |                               | 33. Registrar's Name<br><b>John Andrew Randall</b>  |  | 34. Registrar's Title<br><b>Registrar</b>  |  | 35. Registrar's Address<br><b>6490 Landover Road, Landover, Maryland 20785</b>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23764

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |   |   |  |
|--|---|---|--|--|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy Leader</b>                                   |   |  |  | 2. Date of Death<br>Month <b>July</b> , Day <b>6</b> , Year <b>1997</b> |   | 3. Time of Death<br><b>8:05 PM</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>20499 Chestnut Ridge Drive</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>              |   | 4c. County of Death<br><b>St. Mary's</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>396-18-4939</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.                        |   | 8. Date of Birth (Month, Day, Year)<br><b>April 8, 1923</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Wisconsin</b>  |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>  |   | 10c. City, Town or Location<br><b>Leonardtown</b>           |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>20499 Chestnut Ridge Drive</b>   |  | 10f. Zip Code<br><b>20650</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Refinisher</b>  |  | 16b. Kind of Business/Industry<br><b>Cabinetmaker</b>  |   | 17. Father's Name (First, Middle, Last)<br><b>Anton Sampolinski</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Julia Romanowicz</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Yvonne Joyce, Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20499 Chestnut Ridge Drive, Leonardtown, MD 20650</b>  |   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |   | 20c. Date<br><b>7/8/97</b>  |  | 20d. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |   | 21. Signature of Funeral Service Licensee<br><br><b>Michael R. Blankenship</b>  |   |  |
| 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CARCINOMA</b><br>Due to (or as a consequence of):<br>b. <b>PANCREATIC CARCINOMA</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br><b>2 hours</b><br><b>2 hours</b>   |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined |   | 28a. Date of Injury (Month, Day, Year)  |   |  |
| 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><br><b>Thomas M. Howard MD</b>   |   | 29c. License number<br><b>D34539</b>  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>7. 7. 97</b>   |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Kenneth M. Howard MD 22576 Monticello Boulevard, CRANFORDIA MD 20615</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JUL - 9 1997</b>   |   | 32. Registrar's Signature<br><br><b>Julia Brinsfield-Randall</b>   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23765

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hermann C. Lauritzen

2. Date of Death

Month Day Year  
July 16 1997

3. Time of Death

8:00 am

4a. Facility Name (If not institution, give street and number)

Carroll Lutheran Village

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

579-05-2252

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 5 1902

9. Birthplace (State or Foreign Country)

Denmark

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

201 St. Mark Way Apt. 100

10f. Zip Code

21158

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

4 College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

athletic trainer

16b. Kind of Business/Industry

college

17. Father's Name (First, Middle, Last)

Hans Christian Lauritzen

18. Mother's Name (First, Middle, Maiden Surname)

Maren Marie Kable

19a. Informant's Name/Relationship (Type, Print)

Solveig Smith, daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2519 Marston Road S., New Windsor, MD 21776

20a. Method of Disposition

1 ☐ Burial ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Carroll Cremations Inc.

7/18/97 Date

20c. Location - City or Town, State

Hampstead, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Pritts Funeral Home &amp; Chapel

412 Washington Rd., Westminster, MD

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)a. End Stage Cardiovascularity  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 yr

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Hypertension  
Due to (or as a consequence of):

3 mos

c. Peripheral Vascular Disease  
Due to (or as a consequence of):

5 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Arterial Rheumatism

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

037449

July 17th 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Boydaschev, 205 St. Mark Way, Westminster, MD 21157

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's signature

John Andrew Carroll

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23766

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |
|--|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>ROSE MATT HEWS</i>  |  |   |  | 2. Date of Death<br>Month <i>July</i> Day <i>11</i> Year <i>1997</i>   |  | 3. Time of Death<br><i>16:15 PM</i>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>SOUTHERN MARYLAND HOSPITAL</i>  |  |   |  | 4b. City, Town, or Location of Death<br><i>CLINTON</i>   |  | 4c. County of Death<br><i>PRINCE GEORGES</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>579-389091</i>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>76</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>JAN 10 1921</i>                                   |  |
|  | 9. Birthplace (State or Foreign Country)<br><i>WASHINGTON DC</i>   |  | 10a. State<br><i>MD.</i>  |  | 10b. County<br><i>PG</i>   |  | 10c. City, Town or Location<br><i>CAPITAL HEIGHTS</i>                                       |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><i>178 DAIMLER DR.</i>  |  | 10f. Zip Code<br><i>20743</i>  |  | 10g. Citizen of What Country?<br><i>U.S.A</i>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>no</i>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>black</i>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12TH</i> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>LIBRARIAN</i>   |  | 16b. Kind of Business/Industry<br><i>LIBRARY OF CONGRESS</i>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>GROVER HENRY</i>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>ROSIE KELLY</i>  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>EDWARD MATTHEWS</i>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>178 DAIMLER DR. CAPITAL HGT MD. 20743</i>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>MD. NATIONAL MEM PK</i>  |  | 20c. Location - City or Town, State<br><i>7/17/97 laurel md.</i>   |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Leander Coles</i>  |  |   |  | 22. Name and Address of Facility<br><i>6234 3rd ST NW. WASH. DC. TRI-STATE F/S</i>   |  |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><i>Bilateral aspiration pneumonia</i><br>Due to (or as a consequence of):<br><i>old stroke s/p stroke feeds</i>   |  |   |  |  |  |   |  |
|  | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>I week</i>   |  |   |  |  |  |   |  |
|  | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day, Year)  |  | 28b. Time of injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  | 28d. Describe how injury occurred  |  | 28e. Piece of injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |  |  |   |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br><i>Dr. Brown MD Attending</i>   |  |   |  | 29c. License number<br><i>D-24535</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>7/12/97</i>                                       |  |
|  | 30. Name and address of person who completed cause of death (from 23a) (Type, Print)<br><i>Old Branch Ave Clinton Md. 20785</i>  |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 21 1997</i>  |  | 32. Registrar's Signature<br><i>John Michael Roshell</i> |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

100-100-100

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23767

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GOMANZ MOSLEY

2. Date of Death

Month  
JULYDay  
18Year  
1997

3. Time of Death

10:14 PM

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

710-18-5381

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

73 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

MAR. 1, 1924

9. Birthplace (State or Foreign Country)

WEST VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

PRINCE GEORGE'S

10c. City, Town or Location

CAPITAL HEIGHTS

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

604 QUARRY AVE.

10f. Zip Code

20743

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

☒ Yes ☐ No 4/2/43  
If Yes, Give Year or Dates: 1/5/46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

POSTAL WORKER

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

CAMMIE MOSELEY

18. Mother's Name (First, Middle, Maiden Surname)

SALLIE COLES

19a. Informant's Name/Relationship (Type, Print)

ADA BELLE MOSELEY/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

604 QUARRY AVE. CAPITAL HEIGHTS, MARYLAND 20743

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MARYLAND VETERANS

Date

7/23/97

20c. Location - City or Town, State

CHELTENHAM, MARYLAND

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

ALEXANDER S. POPE FUNERAL HOMES

5538 MARLBORO PIKE/FORESTVILLE, MD. 20747

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ETHANOL ABUSE

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient☒ Outpatient☐ DOA

28. Place of Death (Check only one)

Other:

☐ Nursing Home☐ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33954

29d. Date signed (Month, Day, Year)

JULY 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

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15



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23768

## Certificate of Death

Reg. No.

|   |   |   |  |  |  |   |  |  |
|---|---|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Herbert Augustus Moorman Sr.</b>                       |   |  |  | 2. Date of Death<br>Month Day Year<br><b>July 21, 1997</b> |   | 3. Time of Death<br><b>4:35 PM</b>                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Gladys Spellman Nursing Home</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Cheverly</b>    |   | 4c. County of Death<br><b>Prince George's Co.</b>            |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-36-4172</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.           |   | 8. Date of Birth (Month, Day, Year)<br><b>April 11, 1929</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Washington D.C.</b>                                    |   | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>P.G.</b>                                 |   | 10c. City, Town or Location<br><b>Hyattsville</b>            |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>5701 43rd. Ave. Apt.2</b>  |  | 10f. Zip Code<br><b>20781</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Truck Driver</b>  |  | 16b. Kind of Business/Industry<br><b>Trucking</b>  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Samuel Auston Moorman</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucinda Bredin</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Lilly May Moorman/ Wife</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5701 43rd AVE. #2, Hyattsville, Md. 20781</b>  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>   |  | 20c. Date<br><b>7/26/97</b>  |  | 20d. Location - City or Town, State<br><b>Brentwood, Md.</b>                                |  |  |
| 21. Signature of Funeral Service Licensee<br> <b>MO0091</b>   |   |   |  | 22. Name and Address of Facility<br><b>CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Sepsis due to Methicillin Resistant Staph Aureus</b> <b>weeks</b><br>Due to (or as a consequence of):<br>b. <b>GENERAL DEBILITY</b> <b>months</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE Lung disease</b><br><b>Arteriosclerotic Cardiovascular Disease</b>   |   |   |  |  |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |  |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>NIA</b>  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 29c. License number<br><b>DO1852</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 22 1997</b>                                  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>PAUL A. DEVORE, MD 4203 Queensbury Rd Hyattsville MD 20781</b>   |   |   |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>   |   | 32. Registrar's Signature<br>  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

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Physician  
/Medical  
Examiner

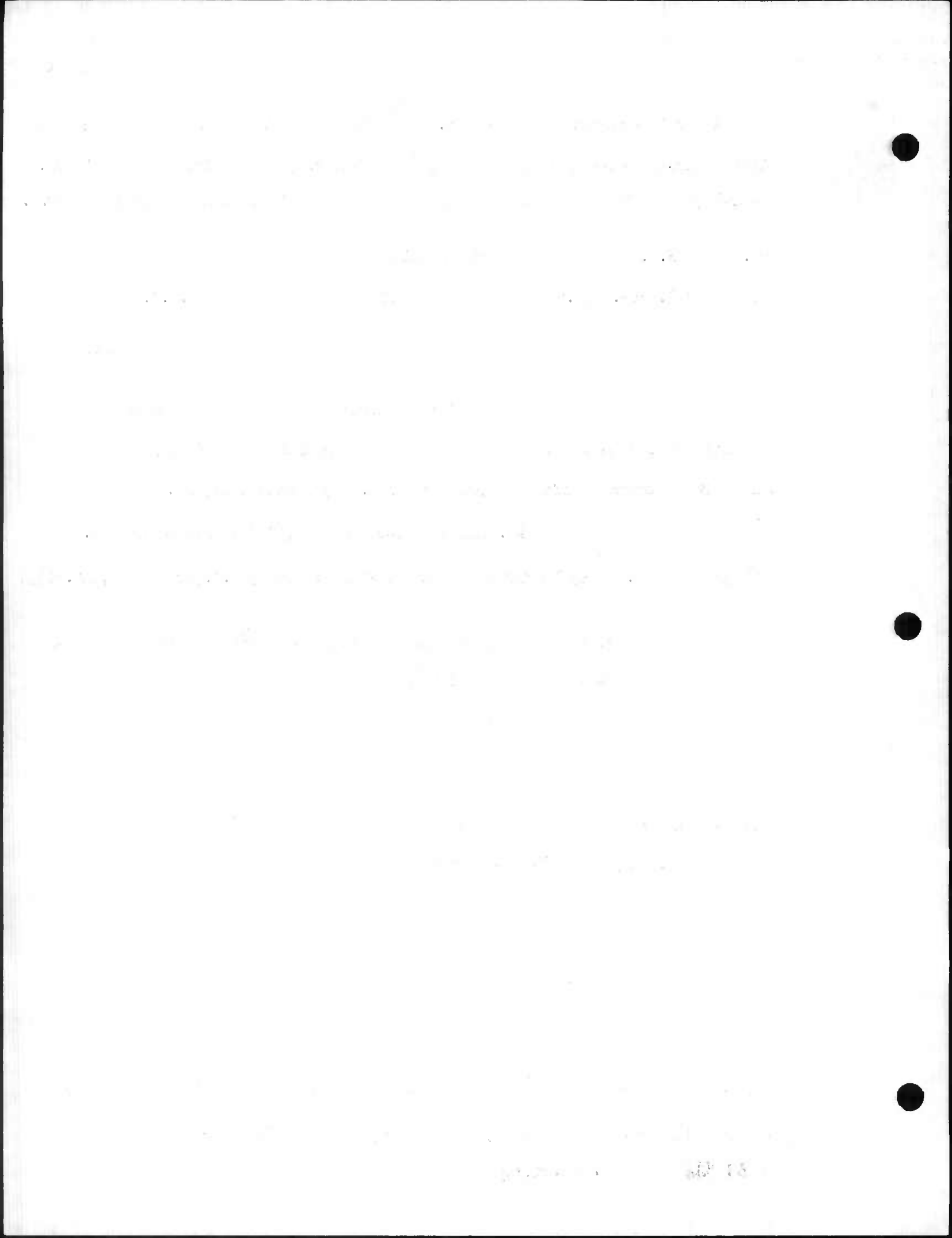
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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23769

## Certificate of Death

Reg. No.

|  |  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Louise C. Mockabee                     |  |  |   | 2. Date of Death<br>Month Day Year<br>July 17, 1997  |  | 3. Time of Death<br>5:15 PM  |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>201 Bay City Rd. |  |  |   | 4b. City, Town, or Location of Death<br>Stevensville |  | 4c. County of Death<br>Queen Annes   |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>579-88-1495   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>81 Yrs.            |  | 8. Date of Birth (Month, Day, Year)<br>Nov. 30, 1915   |   | 9. Birthplace (State or Foreign Country)<br>Hume, Virginia |  |  |
|  | Usual Residence of Decedent  |  |  |   | 10c. City, Town or Location<br>Stevensville          |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Queen Annes   |  | 10f. Zip Code<br>21666  |  |  |  | 10g. Citizen of What Country?<br>USA  |  |  |  |
| 10e. Street and Number<br>201 Bay City Rd.   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Housewife   |  | 16b. Kind of Business/Industry<br>At Home   |  |  |  |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br>Marshall Andrew Edwards   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Carey Belle Mitchell   |  |  |  |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Delores Link/Daughter  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as item 10  |  |  |  |   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington Nat. Cemetery  |  | Data<br>7/24/97   |  | 20c. Location - City or Town, State<br>Arlington, Virginia   |  |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br>George P. Kalas Funeral Home<br>6160 Oxon Hill Rd. Oxon Hill, Md. 20745   |  |  |  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br>4 MONTHS  |  |  |  |
| LUNG CANCER<br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):  |  |  |  |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |  |  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
|  |  |  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.                      |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>D16364   |  | 29d. Date signed (Month, Day, Year)<br>7/21/97   |  |   |  |  |  |
| 30. Name and address of person who completed cause of death (item 23a) (Type, Print)<br>PETER R GAZE MD 900 Bestgate Rd. Annapolis, Md. 21401  |  |  |  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1997   |  |  |  | 32. Registrar's Signature<br>  |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23770

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Marion

Eugene

Malone

2. Date of Death

Month

Day

Year

July

20

1997

3. Time of Death

1:21 A.M.

4a. Facility Name (If not institution, give street and number)

3700 Media Lane

4b. City, Town, or Location of Death

Bowie

4c. County of Death

Prince George's

5. Social Security Number

442 22 5685

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

71

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

March 19, 1926

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3700 Media Lane

10f. Zip Code

20715

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MSGT

16b. Kind of Business/Industry

United States

Army.

17. Father's Name (First, Middle, Last)

Marion Francis Malone

18. Mother's Name (First, Middle, Maiden Surname)

Gladys Sawyer

19a. Informant's Name/Relationship (Type, Print)

Loretta D. Malone

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3700 Media Lane Bowie Maryland 20715

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Maryland Veterans Cemetery

July 23, 1997

20c. Location - City or Town, State

Crownsville Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.  
16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. METASTATIC COLORECTAL CANCER.

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

28 mos.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33446

29d. Date signed (Month, Day, Year)

22 July 97

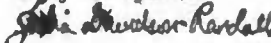
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANK J. WARD MD, Home One LUTHERAN LUTHER DC 20307

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23771

Reg. No.

|  |  |   |  |  |  |  |  |  |
|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>OJUE E. MACFOY</b>                          |   |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>22</b> Year <b>1997</b> |  | 3. Time of Death<br><b>09:24 AM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>6309 TUCKERMAN ST</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>RIVERDALE</b>             |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-33-1466</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>70</b> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>October 24, 26</b>                                   | 9. Birthplace (State or Foreign Country)<br><b>Sierra Leone, W.A</b> |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>   |  | 10c. City, Town or Location<br><b>Riverdale</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>6309 Tuckerman Street</b>   |  |   |  | 10f. Zip Code<br><b>20737</b>  |  | 10g. Citizen of What Country?<br><b>Sierra Leone, W.A.</b>   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Business Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Private</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Sidney Coker</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Connie Young</b>   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Valerie Williams/Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6309 Tuckerman Street, Riverdale, Maryland 20737</b>                                     |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gate of Heaven Cemetery</b>  |  | Date<br><b>08/02 1997</b>  |  | 20c. Location - City or Town, State<br><b>Silver Spring, Maryland</b>  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Nancy A. Perentie</b>  |  |   |  | 22. Name and Address of Facility<br><b>J. B. JENKINS FUNERAL HOME<br/>7474 Landover Road, Landover, Maryland 20785</b>   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. HYPERTENSIVE CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death                         |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)                                     |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                                    |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  | 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><b>[Signature] DME</b>  |  |   |  | 29c. License number<br><b>D 339154</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 24, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARIO F. GOMEZ JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>   |  |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>  |  |   |  | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. The first part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 1010 Pine Street, New York, NY 10004; and 1212 Cedar Street, New York, NY 10005.

2. The second part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 1010 Pine Street, New York, NY 10004; and 1212 Cedar Street, New York, NY 10005.

3. The third part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 1010 Pine Street, New York, NY 10004; and 1212 Cedar Street, New York, NY 10005.

4. The fourth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 1010 Pine Street, New York, NY 10004; and 1212 Cedar Street, New York, NY 10005.

5. The fifth part of the document is a list of names and addresses. The names are written in a cursive hand, and the addresses are written in a more formal, printed hand. The list is organized into columns, with names in the first column and addresses in the second column. The names are: John Doe, Jane Smith, Robert Brown, Mary White, and Thomas Green. The addresses are: 123 Main Street, New York, NY 10001; 456 Elm Street, New York, NY 10002; 789 Oak Street, New York, NY 10003; 1010 Pine Street, New York, NY 10004; and 1212 Cedar Street, New York, NY 10005.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23772

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

BETTY LEE MATTHAI

2. Date of Death  
Month Day Year

July 21, 1997

3. Time of Death

8:00 AM

4a. Facility Name (If not institution, give street and number)

12 Spesutia Road

4b. City, Town, or Location of Death

Aberdeen

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

219-22-2391

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

69

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

6. Date of Birth  
(Month, Day, Year)

Aug. 27, 1927

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Aberdeen

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

12 Spesutia Road

10f. Zip Code

21001

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.  
Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Office Manager

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

Lee Mace Willey

18. Mother's Name (First, Middle, Maiden Surname)

Vida M. Krieger

19a. Informant's Name/Relationship (Type, Print)

Charles G. Matthai, husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

12 Spesutia Road, Aberdeen, Maryland 21001

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

R. A. Ferris & Co., Inc.

Date

7/23/97

20c. Location - City or Town, State

West Chester, PA

21. Signature of Funeral Service Licensee

Howard K. McComas

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 21009

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

e. Lung Cancer

Approximate  
Interval Between  
Onset and Death

1 year

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

28c. Injury at  
Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and Title of Certifier

Sub. Paul

29c. License number

028339

29d. Date signed (Month, Day, Year)

July 27, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA FRIEDICH 101 E Wheel Road Bel Camp 21015

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Sub. Paul

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23773

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Herman

Mittelberg

2. Date of Death

Month  
JulyDay  
20, 1997

3. Time of Death

1:05 AM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

578-01-4706

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 9, 1915

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

11125 Norlee Drive

10f. Zip Code

20902

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No.

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

Collage (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Owner

16b. Kind of Business/Industry

Beauty Salon

17. Father's Name (First, Middle, Last)

Samuel Mittelberg

18. Mother's Name (First, Middle, Maiden Surname)

Anna Schulman

19a. Informant's Name/Relationship (Type, Print)

Ethel Mittelberg (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11125 Norlee Dr., Silver Spring, MD. 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

King David Mem. Gardens 7-22-97 Falls Church, Virginia

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Danzansky-Goldberg Mem. Chapels, Inc

1170 Rockville Pike, Rockville, MD. 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

Acute Myocardial Infarction

Approximate  
Interval Between  
Onset and Death

Hours

a. Due to (or as a consequence of):

Coronary Artery Disease

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Accident

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D36192

29d. Date signed (Month, Day, Year)

July 20, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anes Ahsan

7610 CARROLL AVE. SUITE 380, TAKOMA PARK, MARYLAND 20912

State

Registrar

32. Registrar's Signature

Julia Davidson-Rendell

JUL 22 1997

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23774

Reg. No.

|  |  |   |  |   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|--|--|---|--|---|---|---|---|--|--|---|----|---------------------|----------------------------------|--------|----|---------------------------|----------------------------------|---------|----|--|----------------------------------|--|----|--|----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Hazel Biddle McDonough                             |   |  |   |   |   | 2. Date of Death<br>Month Day Year<br>July 16, 1997   |  | 3. Time of Death<br>11:30am                              |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>407 Russell Avenue Apt. #702 |   |  |   |   |   | 4b. City, Town, or Location of Death<br>Gaithersburg  |  | 4c. County of Death<br>Montgomery                        |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| Funeral<br>Director  | 5. Social Security Number<br>222-12-9025   |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>83 Yrs. |   | 8. Date of Birth (Month, Day, Year)<br>March 17, 1914 |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  | Usual Residence of Decedent  |   |  |   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 10a. State<br>Maryland   |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Gaithersburg   |   |   |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 10e. Street and Number<br>407 Russell Avenue Apt. #702   |  |   |  | 10f. Zip Code<br>20877  |   |   |   | 10g. Citizen of What Country?<br>United States   |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |   |   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4or 5+) 12  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Bookkeeper   |   |   |   | 16b. Kind of Business/Industry<br>Gas Company  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 17. Father's Name (First, Middle, Last)<br>Robert Ira Biddle   |  |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bridget Mae Gillum   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dr. Robert McDonough (Son)   |  |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>11101 Wood Elves Way, Columbia, MD 21044 |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion Methodist Church Cemetery  |   | Date<br>July 21, 1997   |   | 20c. Location - City or Town, State<br>Mechanicsville, MD  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br>DeVol Funeral Home<br>10 East Deer Park Drive<br>Gaithersburg, MD 20877   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>e.</td> <td>Cerebral Thrombosis</td> <td>Due to (or as a consequence of):</td> <td>1 hour</td> </tr> <tr> <td>b.</td> <td>Cerebral Arteriosclerosis</td> <td>Due to (or as a consequence of):</td> <td>5 years</td> </tr> <tr> <td>c.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> |  |   |  |   |   |   |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | e. | Cerebral Thrombosis | Due to (or as a consequence of): | 1 hour | b. | Cerebral Arteriosclerosis | Due to (or as a consequence of): | 5 years | c. |  | Due to (or as a consequence of): |  | d. |  | Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | e.   | Cerebral Thrombosis   | Due to (or as a consequence of):   | 1 hour  |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  | b.   | Cerebral Arteriosclerosis   | Due to (or as a consequence of):   | 5 years   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  | c.   |   | Due to (or as a consequence of):   |   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  | d.   |   | Due to (or as a consequence of):   |   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |   |   |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  |  |   |  |   |   |   |   | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  |  |   |  |   |   |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  |   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  |  |   |  | 28d. Describe how Injury occurred   |   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br>   |   |   |   | 29c. License number<br>07231   |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br>July 16, 1997  |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>James R. Moore Jr. 207 Brookes Ave Gaithersburg MD 20877   |  |   |  |   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 21 1997   |  |   |  | 32. Registrar's Signature<br>   |   |   |   |  |  |   |    |                     |                                  |        |    |                           |                                  |         |    |  |                                  |  |    |  |                                  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

3

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23775

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Catherine Honora McCarron

2. Date of Death

Month Day Year  
July 17 1997

3. Time of Death

8:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Thomas More Nursing and Rehabilitation

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

5. Social Security Number

579-18-6194

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 29, 1919

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

N/A

10b. County

N/A

10c. City, Town or Location

Washington, DC

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2301 N Street, Apt #303, NW

10f. Zip Code

20037

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Instructor of Home Economics

16b. Kind of Business/Industry

Education

17. Father's Name (First, Middle, Last)

Joseph Jerome McCarron

18. Mother's Name (First, Middle, Maiden Surname)

Honora Agnes Minitor

19a. Informant's Name/Relationship (Type, Print)

Mary Boyle

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1269 Halstead Road, Baltimore, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Olivet Cemetery

Date

7/22/97

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cancer of Breast with Metastasis

2 Years

Due to (or as a consequence of):

b. Dehydration

1 Week

Due to (or as a consequence of):

c. Chronic Obstructive Lung Disease

5 Years

Due to (or as a consequence of):

d. Metabolic Imbalance

1 Week

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D19609

29d. Date signed (Month, Day, Year)

July 18, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Raman Tuli, 3503 Perry Street, Suite B, Mt. Rainier, MD 20712

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

10



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23776

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Virginia Isabelle Mohler

2. Date of Death

Month Day Year  
July 19 1997

3. Time of Death

9:25 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number  
579-28-4469

6. Sex  
1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)  
73 Yrs.

If Under 1 Year  
Months Days

If Under 24 Hrs.  
Hours Min.

8. Date of Birth  
(Month, Day, Year)  
Aug. 10, 1923

9. Birthplace (State or Foreign  
Country)  
Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Takoma Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6709 Allegheny Avenue

10f. Zip Code

20912

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.  
Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)  
11

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Dewey Humphries

18. Mother's Name (First, Middle, Maiden Surname)

Alma Gilbert

19a. Informant's Name/Relationship (Type, Print)

Phillip J. King / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9731 Hagle Circle, Lorton, Virginia 22079

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Parklawn Memorial Park

Date

7/23/97

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Hines-Rinaldi Funeral Home  
11800 New Hampshire Avenue  
Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Breast Cancer

Approximate  
Interval Between  
Onset and Death

2 years

Due to (or as a consequence of):

b. Fulminant Hepatic Failure

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy  
performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined

28a. Date of Injury  
(Month, Day Year)

28b. Time of  
Injury

28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

29a. Certifier  
(Check only  
one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

*[Signature]* MD

29c. License number

D 33224

29d. Date signed (Month, Day, Year)

JULY 20 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R Trehan 50 W Edmonston Dr Rockville MD 20852

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

*[Signature]*

State  
Registrar

Baltimore, Maryland 21215-0020

permits. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23777

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LoElla Carolyn Martin

2. Date of Death

Month Day Year  
July 19 1997

3. Time of Death

5:15 AM

4a. Facility Name (If not institution, give street and number)

National Lutheran Home

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

369-01-2938

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

83 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 14, 1914

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9701 Veirs Drive

10f. Zip Code

20850

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Leon German

18. Mother's Name (First, Middle, Maiden Surname)

Blanche Power

19a. Informant's Name/Relationship (Type, Print)

Jeanne H.C. Day

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

760 Rosemont Drive, Panama City, FL 32405

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Deep Dale Memorial Park

Date

7/24/97

20c. Location - City or Town, State

Lansing, MI

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis J. Collins Funeral  
Home, Inc. 500 University Blvd. West  
Silver Spring, MD 2090123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Aspiration pneumonia

Due to (or as a consequence of):

b. Cerebrovascular accident

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

12 days

11 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Advanced Alzheimer's disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D21726

29d. Date signed (Month, Day, Year)

July 19, 1997

30. Name and address of person who completed Cause of death (Item 23e) (Type, Print)

Charles W. Karesh 26033 Ridge Road, Damascus, MD 20872

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Amended #19b, 7/24/97, JW, Montg. Cty

Certificate of Death

Reg. No.

97 23778

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Fritz

2. Date of Death

Month July Day 20 Year 1997

3. Time of Death

10:47 PM

4e. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

064-16-4746

6. Sex

Male ☒ Female ☐

7. Age (In yrs. last birthday)

83

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month April Day 18 Year 1914

9. Birthplace (State or Foreign Country)

Austria

Usual Residence of Decedent

10a. State

Connecticut Litchfield

10b. County

10c. City, Town or Location

Torrington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

180 Ledge Drive

10f. Zip Code

06790

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

☐ Yes ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: white

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (14 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cellist/Cello Teacher

16b. Kind of Business/Industry

Indiana University

17. Father's Name (First, Middle, Last)

Paul Magg

18. Mother's Name (First, Middle, Maiden Surname)

Helena Zimmermann

19e. Informant's Name/Relationship (Type, Print)

Kari Magg/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

180 Ledge Drive Torrington, CT 06790

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Francis New

Date

7/24/97

20c. Location - City or Town, State

Torrington, CT

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Takoma Funeral Home, Inc.  
254 Carroll St. NW Washington, DC 20012

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☐ Yes ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

☐ Yes ☒ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☒ ER/Outpatient ☐ DOA

Other: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending Investigation  
☐ Accident ☐ Could not be determined  
☐ Suicide ☐ Homicide

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Solow Tauber 8218 Wisconsin Ave Bethesda

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23779

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

William Robert MacFarlane

2. Date of Death

Month Day Year  
JUNE 30, 1997

3. Time of Death

07:52 A

4a. Facility Name (If not Institution, give street and number)

ST. MARYS HOSPITAL ER

4b. City, Town, or Location of Death

Leonardtwn

4c. County of Death

ST. MARYS

Funeral  
Director

5. Social Security Number

577-50-9656

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
November 30, 1938

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Calvert

10c. City, Town or Location

Lusby

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2785 Spout Lane

10f. Zip Code

20657

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Distributor

16b. Kind of Business/Industry

Bread Company

17. Father's Name (First, Middle, Last)

Donald Malcom MacFarlane

18. Mother's Name (First, Middle, Maiden Surname)

Mildred Maxine Payne

19a. Informant's Name/Relationship (Type, Print)

Ann L. MacFarlane, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2785 Spout Lane, Lusby, Maryland 20657

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Greenbrier Burial Park

Date

7-5-1997 Hinton, West Virginia

20c. Location - City or Town, State

21. Signature of Funeral Home Director

Michael K. Blankenship, MO0852

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, Maryland 20650-0279

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Hypertensive Arteriosclerotic Cerebrovascular Disease*  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

4 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

4 ☒ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Theodore M. King

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 01, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL -2 1997

32. Registrar's Signature

John Anderson-Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23780

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Grace Field May   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 12, 1997  |  | 3. Time of Death<br>5:55 AM  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>St. MARY'S Nursing Center   |  |   |  | 4b. City, Town, or Location of Death<br>Leonardtown  |  | 4c. County of Death<br>St. Mary's  |  |
| Funeral<br>Director   | 5. Social Security Number<br>215-28-3830  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>66 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>May 30, 1931                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10. Usual Residence of Decedent<br>10a. State<br>Maryland   |  | 10b. County<br>St. Mary's  |  | 10c. City, Town or Location<br>Lexington Park  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>412 Great Mills Road  |  | 10f. Zip Code<br>20653   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>12th Grade  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |  | 16b. Kind of Business/Industry<br>Own Home   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Arthur Field Lindley   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elsa Rebecca Mullen   |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>Theresa Lynn Fields/Daughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>10714 Pelican Drive, Wellington, FL 33414   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>MD Veterans Cemetery  |  | 20c. Date<br>7/16/97   |  | 20d. Location - City or Town, State<br>Cheltenham, Maryland                          |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Michael L. Gardiner</i>   |  |   |  | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650  |  |  |  |
|   | 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |
|   | 23b. Immediate Cause (Final disease or condition resulting in death)<br>? Cardiac arrest  |  |   |  |  |  |  |  |
|   | 23c. Due to (or as a consequence of):<br>a. Cor-P<br>b. paroxysmal A FPG.<br>c.<br>d.   |  |   |  |  |  |  |  |
| 23d. Approximately Interval Between Onset and Death<br>5 min.<br>few yrs<br>few yrs |   |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input checked="" type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  |  |  |  |  |
|   | 29b. Signature and title of certifier<br><i>A. D. Shah</i>  |  |   |  | 29c. License number<br>D 47066   |  | 29d. Date signed (Month, Day, Year)<br>7-14-97                                       |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>A.D. Shah, M.D. Hollywood, Maryland 20636   |  |   |  |  |  |  |  |
| State<br>Registrar  | 31. Date filed (Month, Day, Year)<br>JUL 15 1997  |  |   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

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Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23781

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marion Eileen Murphy

2. Date of Death

Month Day Year  
July 16, 1997

3. Time of Death

1:28 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

071-38-7750

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 13, 1925

9. Birthplace (State or Foreign Country)

Canada

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

45535 Camelot Court

10f. Zip Code

20653

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Bookkeeper

16b. Kind of Business/Industry

Industrial

17. Father's Name (First, Middle, Last)

Coatsworth Peart

18. Mother's Name (First, Middle, Maiden Surname)

Sarah Hewitt

19a. Informant's Name/Relationship (Type, Print)

Marian Murphy Holley, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45535 Camelot Court, Lexington Park, Maryland 20653

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7-16-1997

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Director

Michael K. Blankenship, MD0852

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, Maryland 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Probable Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD

CAD

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☒ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

William D. Boyd II, M.D.

29c. License number

D14285

29d. Date signed (Month, Day, Year)

7-16-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William D. Boyd II, M.D., 25365 Point Lookout Road, Leonardtown, Maryland 20650-1753

31. Date filed (Month, Day, Year)

JUL 17 1997

32. Registrar's Signature

John Brinsfield

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerEileen Marion Murphy  
Division of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23782

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>HERMAN JOSHUA MARTIN  |  |  |  | 2. Date of Death<br>Month Day Year<br>July 16, 1997  |  | 3. Time of Death<br>1:15 PM   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>3656 Black Rock Road  |  |  |  | 4b. City, Town, or Location of Death<br>Upperco  |  | 4c. County of Death<br>Baltimore  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>215-36-8190  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>81 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Dec 21, 1915   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland   |  | 10b. County<br>Baltimore   |  | 10c. City, Town or Location<br>Upperco  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>3656 Black Rock Road   |  | 10f. Zip Code<br>21155   |  | 10g. Citizen of What Country?<br>USA  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                            |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Self Employed   |  | 16b. Kind of Business/Industry<br>Farming  |  | 17. Father's Name (First, Middle, Last)<br>Clarence Martin                                  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bertie Armacost  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Eleanor Martin, Wife   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3656 Black Rock Rd. Upperco, MD 21155   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Mt. Zion Cemetery  |  | 20c. Location - City or Town, State<br>7/19 Upperco, MD  |  | 21. Signature of Funeral Service Licensee<br>Steven W. Elme                                 |  |
|   | 22. Name and Address of Facility<br>Eline Funeral Home<br>934 South Main St, Hampstead, MD 21074  |  | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Cerebrovascular Accident<br>Due to (or as a consequence of):<br>Diabetes Mellitus<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>b. Arteriosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>c.<br>d. |  | Approximate Interval Between Onset and Death<br>2 days<br>16 yrs<br>16 yrs   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>Dr. Faustino  |  | 29c. License number<br>D12901  |  | 29d. Date signed (Month, Day, Year)<br>7/17/97  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>D.V. Faustino, MD 4111 Lower Beckleysville Rd. Hampstead, MD 21074  |  |  |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br>JUL 22 1997  |  | 32. Registrar's Signature<br>John Davidson Randall   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23783

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George B. Muth

2. Date of Death

Month  
JulyDay  
18thYear  
1997

3. Time of Death

11:00 pm

4a. Facility Name (If not institution, give street and number)

Carroll Northern Nursing Home

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

5. Social Security Number

212-07-0145

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
AUG 19, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

CARROLL

10c. City, Town or Location

FINKSBURG

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2809 LAWDALE ROAD

10f. Zip Code

21048

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

INSPECTOR

16b. Kind of Business/Industry

WESTERN ELECTRIC

17. Father's Name (First, Middle, Last)

CHARLES A. MUTH, SR

18. Mother's Name (First, Middle, Maiden Surname)

MARY BURNHAM

19a. Informant's Name/Relationship (Type, Print)

GLADYS MUTH, WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2809 LAWDALE RD, FINKSBURG, MD 21048

20a. Method of Disposition

1 ☐ Burial2 ☒ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CARROLL CREMATIONS

Date

7/21

20c. Location - City or Town, State

HAMPSTEAD, MD

21. Signature of Funeral Service Licensee

Steven W. Eline

22. Name and Address of Facility

ELINE FUNERAL HOME

934 SOUTH MAIN ST, HAMPSTEAD, MD 21074

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe Chronic Obstructive Pulmonary Disease

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Few yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Hypertension

Due to (or as a consequence of):

c. Cirrhosis

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral Cyanosis, Normocytic Anemia

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

(Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Alexander Bogdanovskiy, MD

29c. License number

D37949

29d. Date signed (Month, Day, Year)

July 21st 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alexander Bogdanovskiy, MD, 205 St. Mark's Westminister MD 21072

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John A. Anderson

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23784

|  |   |  |   |   |  |                                |  |  |
|--|---|--|---|---|--|--------------------------------|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>Mary Louise McGrain   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 18, 1997  |                                | 3. Time of Death<br>0430   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>8899 Frederick Road   |  |   |   | 4b. City, Town, or Location of Death<br>Ellicott City  |                                | 4c. County of Death<br>Howard  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>212-26-0461  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>67 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>April 21, 1930  |  |
|  | 9. Birthplace (State or Foreign Country)<br>Maryland  |  |   |   |  |                                |  |  |
| To Be Completed by Funeral Director              | 10a. State<br>WV  |  | 10b. County<br>Berkley  |   | 10c. City, Town or Location<br>Hedgesville   |                                |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|  | 10e. Street and Number<br>5013 Woods Road   |  |   |   | 10f. Zip Code<br>25427   |                                | 10g. Citizen of What Country?<br>United States   |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>1   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Homemaker  |   | 16b. Kind of Business/Industry<br>Own Home   |                                |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Ambrose Sauer  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Charlotte Parr  |                                |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Michael McGrain/Son   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>79 St. Johns Road Littleton, Pennsylvania 17340   |                                |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Crest Lawn Cemetery   |   | Data<br>7-21-97  |                                | 20c. Location - City or Town, State<br>Marriottsville, MD  |  |
|  | 21. Signature of Funeral Service Licensee<br>Sam A. Collins-Witzke  |  |   |   | 22. Name and Address of Facility<br>Harry H. Witzke's Family Funeral Home, Inc.<br>4112 Old Columbia Pike Ellicott City, MD 21043  |                                |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. Liver metastatic cancer<br>Due to (or as a consequence of):<br>b. Colon Cancer<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |                                |  |  |
|  | Approximate Interval Between Onset and Death<br>10 months<br>2 years  |  |   |   |  |                                |  |  |
| To Be Completed by Physician/Medical Examiner    | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |                                | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|  |   |  |   |   |  |                                | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  |   |  |   |   |  |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |                                |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |                                |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |                                |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |   |  |                                |  |  |
|  | 29b. Signature and title of certifier<br>Hind Hamdan  |  |   |   | 29c. License number<br>DH6473  |                                | 29d. Date signed (Month, Day, Year)<br>July 18, 1997   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Hind Hamdan; 363 S. Cleveland Ave; Hagerstown, MD 21740   |  |   |   |  |                                |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 22 1997 |   | 32. Registrar's Signature<br>John Andrew Russell |   |   |  |                                |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23785

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Kathleen W. Nisbett

2. Date of Death

Month Day Year  
July 22, 1997

3. Time of Death

9:25AM

4a. Facility Name (If not institution, give street and number)

Manor Care- Wheaton

4b. City, Town, or Location of Death

Wheaton

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

257-18-8124

6. Sex

☐ M ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Jan. 15, 1920

9. Birthplace (State or Foreign Country)

Georgia

Usual Residence of Decedent

10e. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

1961 Lewis Avenue

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Henry Roberts

18. Mother's Name (First, Middle, Maiden Surname)

Dora Latham

19a. Informant's Name/Relationship (Type, Print)

Billie E. Thompson/Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 27, Huntingtown, Maryland 20639

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

Date

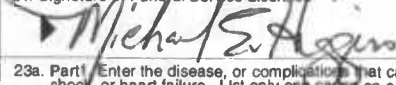
July 25, 1997

20c. Location - City or Town, State

Arlington,

Virginia

21. Signature of Funeral Service Licensee



M00846

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/

Rockville, Inc., 300 West Montgomery Avenue,

Rockville, Maryland 20850-2805

23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Ovarian Cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 Year

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D43237

29d. Date signed (Month, Day, Year)

July 23, 1997

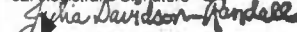
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Armstrong, M.D. 14201 Laurel Park Drive, #102, Laurel, Maryland 20707

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

12



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23786

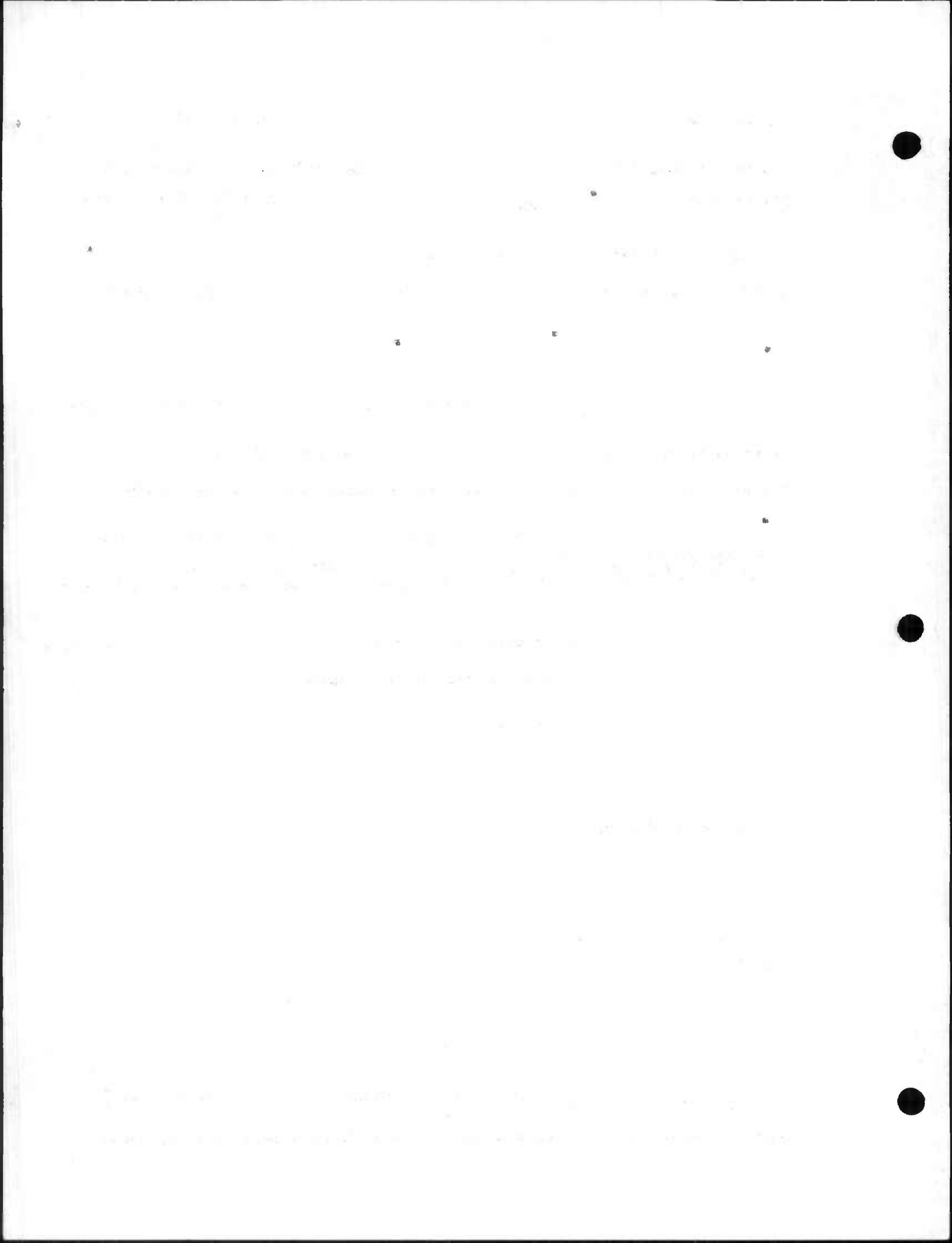
## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Agnes Peach Norris</b>   |  |   |  | 2. Date of Death<br>Month <b>June</b> Day <b>29</b> , Year <b>1997</b>   |  | 3. Time of Death<br><b>7:15 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>   |  | 4c. County of Death<br><b>St. Mary's</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-14-7102</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>April 25, 1909</b>                                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>St. Mary's</b>   |  | 10c. City, Town or Location<br><b>Leonardtown</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>22795 Lawrence Avenue</b>  |  | 10f. Zip Code<br><b>20650</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Social Worker</b>   |  | 16b. Kind of Business/Industry<br><b>State of Maryland</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Alexander Peach</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Josephine Oliver</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Katherine D'Esposito, Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 32, Leonardtown, Maryland 20650</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Queen of Peace</b>   |  | 20c. Location - City or Town, State<br><b>7/3/97 Helen, Maryland</b>   |  | 20d. Date   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Director Licensee<br><b>Edward N. Brinsfield, Jr. MD0052</b>   |  |   |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br><b>Cerebral Thrombosis v/s Embolus</b><br>Due to (or as a consequence of):<br><b>Atherosclerosis</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br><b>48 Hours</b><br><b>48 Hours</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Atrial Fibrillation</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><b>John F. Fenwick, M.D.</b>   |  | 29c. License number<br><b>D01380</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 1, 1997</b>                                  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John F. Fenwick, M.D. 22650 Peabody Street, Leonardtown, Maryland 20650</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>JUL -2 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>John F. Fenwick, M.D.</b>   |  |   |  | 33. Registrar's Title<br><b>John F. Fenwick, M.D.</b>  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23787

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Daniel G. Newton

2. Date of Death

Jul 18 97

Day Year

3. Time of Death

1050A

4a. Facility Name (If not institution, give street and number)

Anne Arundel Medical Center

4b. City, Town, or Location of Death

Annapolis

4c. County of Death

Anne Arundel

Funeral  
Director

5. Social Security Number

276-01-2604

6. Sex

15X M 20 F

7. Age (In yrs. last birthday)

79

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Oct 16, 1917

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

MD

10b. County

Anne Arundel

10c. City, Town or Location

Arnold

10d. Inside City Limits

15X Yes 20 No

10e. Street and Number

290 West Joyce Lane

10f. Zip Code

21012

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married  
30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
10 Yes 20 No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Concrete Products

17. Father's Name (First, Middle, Last)

Ross Newton

18. Mother's Name (First, Middle, Maiden Surname)

Julia Beuttner

19a. Informant's Name/Relationship (Type, Print)

Casey Newton-Daniel

daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

290 West Joyce Lane, Arnold, Maryland 21012

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State  
40 Donation 50 Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Greenwood Cemetery

Date

7/22/97

20c. Location - City or Town, State

Hamilton, Ohio

21. Signature of Funeral Service Licensee

Donaldson Funeral Home, P.A.

22. Name and Address of Facility

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Ischemic Bowel Disease

48 hrs

Due to (or as a consequence of):

b. Liver Failure

48 hrs

Due to (or as a consequence of):

c. Atherosclerotic Cerebrovascular Disease

4 yrs.

Due to (or as a consequence of):

d. Cardiomyopathy

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of cause  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 20 No

26. Place of Death (Check only one)

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural 50 Pending  
20 Accident Investigation  
30 Suicide 60 Could not be  
40 Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?

10 Yes 20 No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Michael Epstein

29c. License number

D34426

29d. Date signed (Month, Day, Year)

JUL 18 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

621 Ridgely Ave Ste 201 Annapolis MD 21401

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

John P. ...

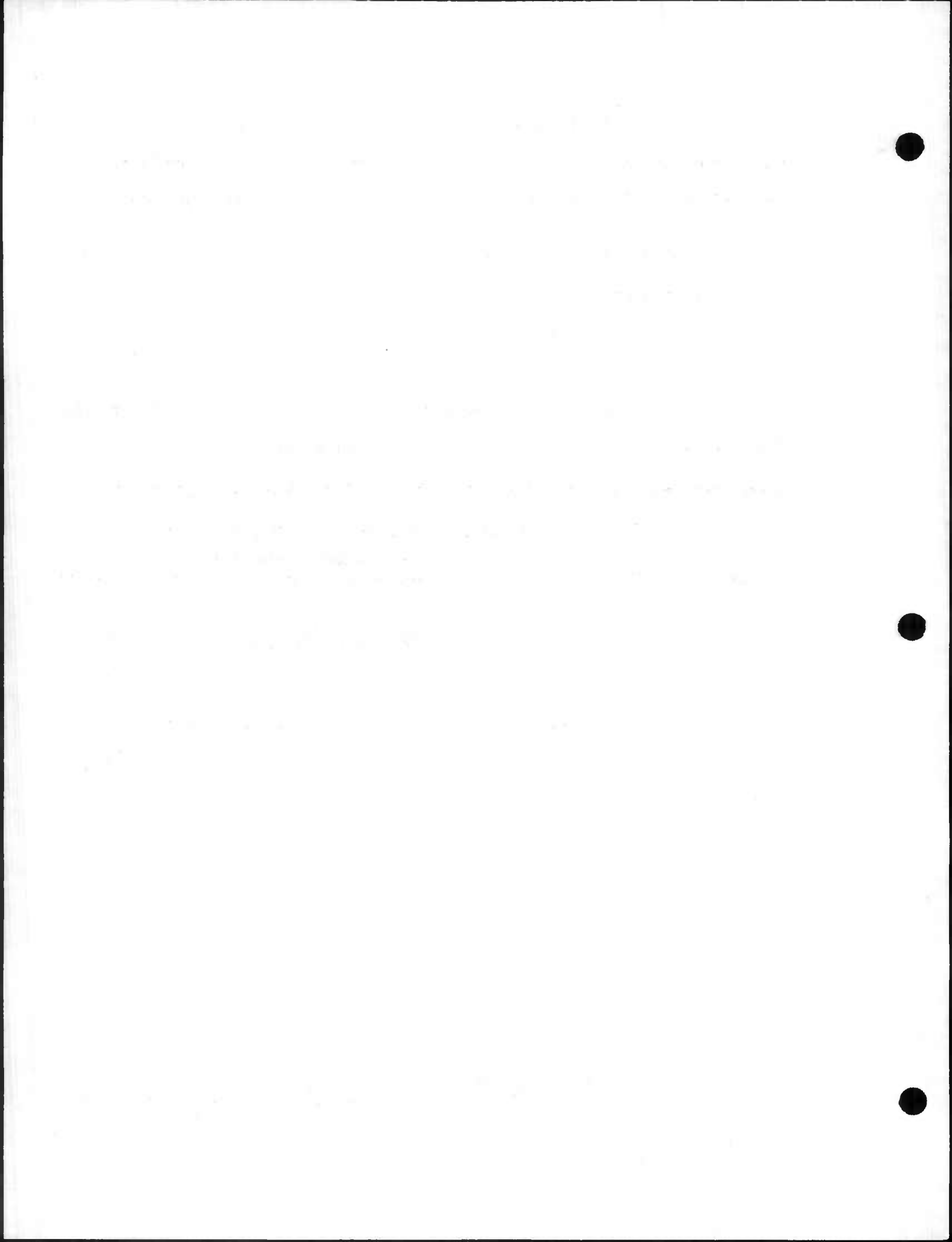
State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23788

## Certificate of Death

Reg. No.

|  |  |   |  |                                      |  |  |  |  |  |
|--|--|---|--|--------------------------------------|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Walter Vane Nichols  |   |  |                                      | 2. Date of Death<br>Month: July Day: 16 Year: 1997   |  | 3. Time of Death<br>3:33 PM  |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>Salisbury Center: Genesis ElderCare  |   |  |                                      | 4b. City, Town, or Location of Death<br>Salisbury, MD  |  | 4c. County of Death<br>Wicomico  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-03-9549   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>81 Yrs.  | If Under 1 Year<br>Months Days       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>April 3, 1916   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|  | Usual Residence of Decedent  |   |  |                                      |  |  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br>Maryland   |   | 10b. County<br>Wicomico  |                                      | 10c. City, Town or Location<br>Salisbury   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|  | 10e. Street and Number<br>914 Tamarac Drive  |   |  |                                      | 10f. Zip Code<br>21804   |  | 10g. Citizen of What Country?<br>USA   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No 1939-<br>If Yes, Give Year or Dates: 1966 |                                      | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                               |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 4   |   |  |                                      | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Chief, Military Personnel   |  | 18b. Kind of Business/Industry<br>U. S. Army   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>George W. Nichols   |   |  |                                      | 18. Mother's Name (First, Middle, Maiden Surname)<br>Omega Vane  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br>Violet R. Nichols/Wife   |   |  |                                      | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>914 Tamarac Drive, Salisbury, Maryland 21804  |  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Arlington National Cem.  |                                      | 20c. Location - City or Town, State<br>Arlington, Virginia   |  | 20d. Date<br>7/25/97   |  |  |
|  | 21. Signature of Funeral Service Licensed  |   |  |                                      | 22. Name and Address of Facility<br>Zeller Funeral Home, 1212 Old Ocean City Road,<br>P.O. Box 3171, Salisbury, Maryland 21802   |  |  |  |  |
|  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |                                      |  |  |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <u>End Stage Alzheimer's Disease</u><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |                                      |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Pneumonia</u>   |  |   |  |                                      |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |  |   |  |                                      |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                      |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of Injury<br>M             |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                      |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><u>[Signature]</u>   |  | 29c. License number<br><u>039813</u> |  | 29d. Date signed (Month, Day, Year)<br><u>7/17/97</u>  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><u>MATKINS MD</u>  |  | 1104 Healthway Dr., Salisbury, MD 21804   |  |                                      |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 28 1997   |  | 32. Registrar's Signature<br><u>[Signature]</u>   |  |                                      |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



1000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23789

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mirerine O'Neal

2. Date of Death

July 22, 1997

Day

Year

3. Time of Death

3:10AM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

255-18-1161A

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

9. Birthplace (State or Foreign Country)

Gay, GA

Usual Residence of Decedent

10e. State

Md.

10b. County

Prince George's

10c. City, Town or Location

North Brentwood

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3911 Webster Street

10f. Zip Code

20722

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

6th

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cafeteria Worker

16b. Kind of Business/Industry

University of GA/  
Private

17. Father's Name (First, Middle, Last)

Robert Atkinson

18. Mother's Name (First, Middle, Maiden Surname)

Mattie Anthony

19e. Informant's Name/Relationship (Type, Print)

Betty Shipp/Niece

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3911 Webster Street, N. Brentwood, MD 20722

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony Memorial Park

Date

7/28/97

20c. Location - City or Town, State

Landover, Maryland

21. Signature of Funeral Service Licensee

Nancy A. Perantoni

22. Name and Address of Facility

J.B. Jenkins Funeral Home

7474 Landover Road, Landover, MD 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Severe chronic obstructive pulmonary disease

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cor pulmonale - Cerebrovascular Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28e. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician2 ☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George C. Hajjar, Jr.

29c. License number

039550

29d. Date signed (Month, Day, Year)

7-22-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

George C. Hajjar, Jr. M.D. 4850 Forbes Blvd Lanham, Md. 20706

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

John M. Parker

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

3

*Journal of Management Studies*, 19(1), 67-80.

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23790

Amended #18, 7/25/97, JW, Montg. Cty.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Irene M. Orsini

2. Date of Death

Month Day Year  
July 19, 1997

3. Time of Death

4:00 am

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

579-32-9154

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

67

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

March 8, 1930

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13724 Drake Drive

10f. Zip Code

20853

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supervisor

16b. Kind of Business/Industry  
Montgomery County  
Division of  
Solid Waste

17. Father's Name (First, Middle, Last)

Joseph R. Hughes

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Beatrice ~~Morgan~~ Moran

19a. Informant's Name/Relationship (Type, Print)

Stephen J. Orsini/ Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13724 Drake Drive Rockville, Maryland 20853

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

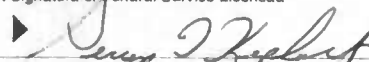
Date

July 23, 1997

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

 M00335

22. Name and Address of Facility

Robert A. Humphrey Funeral Home/  
Rockville, Inc. 300 West Montgomery Avenue  
Rockville, Maryland 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic Small Cell Lung Cancer 2/yrx

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

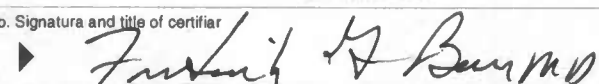
28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier



29c. License number

022775

29d. Date signed (Month, Day, Year)

7-19-97

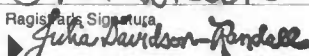
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Frederick G. Barr 5454 Wisconsin Ave Chevy Chase, Md. 20815

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23791

## Certificate of Death

Reg. No.

MICHAEL PRESSLEY

|   |   |   |   |   |  |  |  |  |  |
|---|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL PRESSLEY</b>                                     |   |   |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>14</b> Year <b>1997</b> |  | 3. Time of Death<br><b>3:24 AM</b>   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>              |  | 4c. County of Death<br><b>PRINCE GEORGES</b>   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-90-9538</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                              |   | 7. Age (In yrs. last birthday)<br><b>19</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 23, 1977</b>                                    |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>CHEVERLY, MD.</b>  |   |   |   |  |  |  |  |  |
| Usual Residence of Decedent   |   |   |   |   |  |  |  |  |  |
| 10a. State<br><b>MARYLAND</b>   |   | 10b. County<br><b>PRINCE GEORGE'S</b>   |   | 10c. City, Town or Location<br><b>TEMPLE HILLS</b>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>2027 CHADWICK TERRACE</b>  |   |   |   | 10f. Zip Code<br><b>20748</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>  |  |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STUDENT</b>   |  |  | 16b. Kind of Business/Industry<br><b>SCHOOL</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MICHAEL PRESSLEY, SR.</b>   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>PAMELA HARVEY</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>TANYA MADISON/ COUSIN</b>  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1236 G. STREET N.E. WASHINGTON, D.C. 20002</b>  |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METROPOLITAN CREMATORY</b> |   | Date<br><b>7/18/97</b>   |  | 20c. Location - City or Town, State<br><b>ALEXANDRIA, VA.</b>                                  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Kurt G. Sauer</i> M1085   |   |   |   | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES</b><br><b>5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747</b>   |  |  |  |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Gunshot wound of the Torso</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |
|   |   |   |   |   |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>7-14-97</b>  |   | 28b. Time of Injury<br><b>0113</b> M  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Subject was shot</b><br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>2404 Canning Prince George's County, Maryland</b> |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   | 29b. Signature and title of certifier<br><i>Stephen S. Radentz, MD</i>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>   |   |   |   | 32. Registrar's Signature<br><i>John A. Radentz</i>   |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23792

WILLIAM D. POWELL

## Certificate of Death

Reg. No.

|  |  |  |  |  |  |                                |  |   |
|--|--|--|--|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>WILLIAM DAVID POWELL</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 11 1997</b>  |                                | 3. Time of Death<br><b>10:30 AM</b>  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>2206 HOPE CIRCLE</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>WALDORF</b>   |                                | 4c. County of Death<br><b>CHARLES</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-86-2036</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>31</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>6/9/66</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|  | Usual Residence of Decedent  |  |  |  |  |                                |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Charles</b>  |  | 10c. City, Town or Location<br><b>Waldorf</b>  |                                | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br><b>2206 Hope Circle</b>  |  |  |  | 10f. Zip Code  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Welder</b>   |  | 16b. Kind of Business/Industry<br><b>Private</b>   |                                |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ralph Pwell</b>  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Patricia Carroll</b>   |                                |  |   |
| Physician<br>/Medical<br>Examiner                                    | 19e. Informant's Name/Relationship (Type, Print)<br><b>Patricia Carroll</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1248 Capitol View Dr. Landover, Md. 20785</b>  |                                |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lincoln Cemetery</b>  |  | Date<br><b>7/19/97</b>   |                                | 20c. Location - City or Town, State<br><b>Suitland, Md.</b>                                    |   |
|  | 21. Signature of Funeral Service Licensee<br><i>Janice Edwards</i>   |  | 22. Name and Address of Facility<br><b>Hodges and Edwards<br/>3910 Silver Hill RD. Suitland, Md. 20746</b>   |  |  |                                |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Infarct of heart</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |  |  |  |                                |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |  |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b>   |  |  |                                |  |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>UNK</b>   |  | 28b. Time of Injury<br><b>UNK</b> M  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Residence</b>   |  | 28d. Describe how injury occurred<br><b>Subject shot self</b>  |                                |  |   |
|  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>2206 Hope Circle 20601</b>  |                                |  |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner  |  | 1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |                                |  |   |
| State Registrar  | 29b. Signature and title of certifier<br><i>Janice Edwards MD</i>  |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 12, 1997</b>  |                                |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |  |                                |  |   |
|  | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |  | 32. Registrar's Signature<br><i>John Andrew Powell</i>   |  |  |                                |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

100

100

100

100

100



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23793

## Certificate of Death

Reg. No.

Amended # 206. P.G.C. 7-24-97 CA

|   |   |   |  |   |  |  |   |  |
|---|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Harry S. Price</i>                                   |   |  |   | 2. Date of Death<br>Month <i>July</i> Day <i>19</i> Year <i>1997</i> |  | 3. Time of Death<br><i>9:15 AM</i>                          |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><i>Southern Maryland Hospital</i> |   |  |   | 4b. City, Town, or Location of Death<br><i>Clinton</i>               |  | 4c. County of Death<br><i>Prince George's</i>               |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>215-18-3253</i>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><i>76</i> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><i>Aug. 13, 1920</i> |  |
|   | 9. Birthplace (State or Foreign Country)<br><i>St. Mary's Co. MD</i>                                |   | 10a. State<br><i>Maryland</i>  |   | 10b. County<br><i>Prince George's</i>                                |  | 10c. City, Town or Location<br><i>Forestville</i>           |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><i>2738 Lorrington Drive, Apt. 203</i>  |  | 10f. Zip Code<br><i>20747</i>   |  | 10g. Citizen of What Country?<br><i>United States</i>                            |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>1/8/42</i><br>If Yes, Give Year or Dates: <i>11/4/45</i>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <i>Black</i> |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>          |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Truck Driver (Professional Mover)</i>   |  | 16b. Kind of Business/Industry<br><i>Private/Self Employed</i>  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><i>William Lee Price</i>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Mary Alberta Holt</i>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Marian I. Price - Wife</i>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>2738 Lorrington Drive, Apt 203, Forestville, MD 20747</i>   |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Maryland Veterans Cemetery</i>   |  | 20c. Date<br><i>7/23/97</i>   |  | 20d. Location - City or Town, State<br><i>Cheltenham, Maryland</i>               |   |  |
| 21. Signature of Funeral Service Licensee<br><i>John T. Stewart III</i>   |   |   |  | 22. Name and Address of Facility<br><i>STEWART FUNERAL HOME, Inc.<br/>4001 Benning Road, N. E., Washington, D. C.</i>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Coronary Artery Disease</i> Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |   |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |  |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><i>Renal failure.</i><br><i>Peripheral vasc. dz.</i>  |   |   |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  | 29c. License number<br><i>046478</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>7-20-97</i>                            |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Suresh A. Patel MD 7521 Summerville Rd. #307. Clinton, MD 20735</i>  |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 23 1997</i>   |   | 32. Registrar's Signature<br><i>John A. Randall</i>   |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23794

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MATTIE LEE POTTER

2. Date of Death

Month Day Year  
JULY 21, 1997

3. Time of Death

8:23 AM

4a. Facility Name (If not institution, give street and number)

MARINER OF SOUTHERN MARYLAND

4b. City, Town, or Location of Death

CLINTON

4c. County of Death

PRINCE GEORGE'S

Funeral  
Director

5. Social Security Number

578-28-9914

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

1 15 05

9. Birthplace (State or Foreign Country)

GEORGIA

Usual Residence of Decedent

10a. State

10b. County

10c. City, Town or Location

10d. Inside City Limits

MARYLAND PRINCE GEORGE'S

SUITLAND

XX Yes 2 ☐ No

10e. Street and Number

3940 BEXLEY PLACE #201

10f. Zip Code

20746

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Navar Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3rd

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

DOMESTIC

17. Father's Name (First, Middle, Last)

VINCENT VALDEZ

18. Mother's Name (First, Middle, Maiden Surname)

IDA BALCOM

19a. Informant's Name/Relationship (Type, Print)

MICHELLE VALDEZ/ NIECE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2407 REPTON CT. BALTIMORE, MD 21244

20a. Method of Disposition

XX Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

FT. LINCOLN CEMETERY 7-24-97 BRENTWOOD, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Kauana Braxton

22. Name and Address of Facility

Marshall of Md  
4308 Suitland Rd Suitland, MD 20746

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. Advance Pancreatic Cancer

Due to (or as a consequence of):

b. I D D M

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John D. Randall MD Attending

29c. License number

D-24535

29d. Date signed (Month, Day, Year)

7/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7700 Old Branch Ave Clinton, Md 20735 Suite #C101

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John D. Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



97 23795

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>RAYMOND L. PENN, SR.</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>July</b> DAY <b>21</b> YEAR <b>1997</b>  |  | 3. TIME OF DEATH<br><b>9:50 A. M.</b>   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>579-24-0930</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>71</b> YRS.  |  | 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>Sept. 8, 1925</b>                              |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>Washington Adventist Hospital</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Takoma Park</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  |  |  | 10b. COUNTY<br><b>Prince George's</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Morningside</b>   |  |
| 10d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  |  |  | 10e. STREET AND NUMBER<br><b>4408 Morgan Rd.</b>  |  |   |  |
| 10f. ZIP CODE<br><b>20746</b>  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br><b>Unknown</b>   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) 8th</b>   |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Bus Mechanic</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>P.G. Co. School System</b>   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>Austin J. Penn</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Jessie Jenkins</b>  |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Shirley M. Penn/Wife</b>  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>same as item 10</b>   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory 7/22/97</b>   |  | 20c. LOCATION — City or Town, State<br><b>Alexandria, Va.</b>   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>George P. Kalas</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>George P. Kalas Funeral Home<br/>6160 Oxon Hill Rd. Oxon Hill, Md. 20745</b>   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |   |  |   |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BRADYCARDIA</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |   |  |   |  |
| b. <b>SEVERE HYPOXEMIA</b>   |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| c. <b>PNEUMONIA</b>  |  |  |  |   |  |   |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |   |  |   |  |
| d. <b>BRONCHOGENIC CARCINOMA</b>   |  |  |  |   |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>HEPATIC COMA</b>  |  |  |  |   |  |   |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input type="checkbox"/> NO  |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Samir Neimat, M.D.</i>   |  |  |  | 29c. LICENSE NUMBER<br><b>MD 18551</b>  |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>7/21/97</b>                                       |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>SAMIR NEIMAT, M.D. 7610 CARROLL AV. TAKOMA PARK, MD, 20912</b>   |  |  |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>JUL 23 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John D. ...</i>   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



97-4181-003

B.K.S

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23796

EDWARD PARKER

Items: 23a Part 1, 27 per MEO G-750 8/11/97 dh

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

EDWARD A. PARKER

2. Date of Death

Month

Day

Year

3. Time of Death

1739 PM

4a. Facility Name (If not institution, give street and number)

NORTH ARUNDEL HOSPITAL E.R.

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

5. Social Security Number

216-58-9200

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

43 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 26, 1954

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

13103 - 6th Street

10f. Zip Code

20720

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collega (1-4or 5+)

7th

18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Janitor

18b. Kind of Business/Industry

Government

17. Father's Name (First, Middle, Last)

Charles Parker

18. Mother's Name (First, Middle, Maiden Surname)

Helen Harris

19a. Informant's Name/Relationship (Type, Print)

Helen Harris/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

13103 - 6th Street, Bowie, Maryland 20720

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Cemetery

Date

08/01 1997

20c. Location - City or Town, State

North Brentwood, MD

21. Signature of Funeral Service Licensee

Nancy A. Perconti

22. Name and Address of Facility

J. B. JENKINS FUNERAL HOME

7474 Landover Road, Landover, Maryland 20785

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Stephen S. Radentz, MD

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

JULY 28, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

JUL 30 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23797

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norma Cary Pugh

2. Date of Death

Month Day Year  
July 18, 1997

3. Time of Death

5:15PM

4e. Facility Name (If not Institution, give street and number)

1402 Broadwood Drive

4b. City, Town, or Location of Death

Rockville

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

219-42-2844

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

87

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 9, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Rockville

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1402 Broadwood Drive

10f. Zip Code

20851

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify:

White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Librarian

16b. Kind of Business/Industry

United States  
Government

17. Father's Name (First, Middle, Last)

Richard W. Cary

18. Mother's Name (First, Middle, Maiden Surname)

Nellie Brown

19e. Informant's Name/Relationship (Type, Print)

Patricia Kinder/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1402 Broadwood Drive, Rockville, Maryland 20851

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Rockville Cemetery

Date

July 22, 1997

20c. Location - City or Town, State

Rockville, Maryland

21. Signature of Funeral Service Licensee

Barbara J. McMullen Lawrence

M00831

22. Name and Address of Facility

Robert A. Pumphrey Funeral Home/Rockville, Inc.  
300 West Montgomery Avenue, Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Senile Dementia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

11 years

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24e. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending6 ☐ Investigation7 ☐ Could not be8 ☐ determined28e. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

George S. Kenton, M.D.

29c. License number

D08645

29d. Date signed (Month, Day, Year)

July 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George S. Kenton, M.D. 10620 Georgia Avenue, Silver Spring, Maryland 20902-4152

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23798

## Certificate of Death

Reg. No.

|  |   |  |  |  |  |  |  |  |
|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William Peratino</b>                           |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>15</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:40 AM</b>                        |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>110 Sheffield Street</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>         |  | 4c. County of Death<br><b>Montgomery</b>                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-03-4447</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>May 25, 1916</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>                           |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>                                     |  | 10c. City, Town or Location<br><b>Silver Spring</b>        |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>110 Sheffield Street</b>  |  | 10f. Zip Code<br><b>20910</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW II</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (14 or 5+) <b>5+</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>C.P.A.</b>                                     |  | 16b. Kind of Business/Industry<br><b>Accounting</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Spero Peratino</b>   |  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Epoxia Brandy</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Charlotte Shepherd Peratino/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>110 Sheffield Street, Silver Spring, Maryland 20910</b>                                  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rock Creek Cemetery</b>   |   | 20c. Location - City or Town, State<br><b>Washington, D.C.</b>   |  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Hines-Rinaldi Funeral Home</b><br><b>11800 New Hampshire Avenue</b><br><b>Silver Spring, Maryland 20904</b>   |  |  |
| 23. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>METASTATIC PANCREATIC ADENOCARCINOMA</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>1 YEAR</b> |   | 24. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.                                     |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
| 28d. Describe how Injury occurred  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |
| 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D07285</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 16, 1997</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>JAMES A. BROWN MD 9707 MEDICAL CENTER DRIVE, ROCKVILLE MD 20850</b>   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 18 1997</b>  |   | 32. Registrar's Signature<br>  |  | 33. Registrar's Name<br><b>Jane Anderson-Randall</b>   |  | 34. Registrar's Title<br><b>Registrar</b>  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Important: If item 27 is marked other than "natural", or items 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23799

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Modest M. Parker

2. Date of Death

Month Day Year  
July 23, 1997

3. Time of Death

1:55pm

4a. Facility Name (If not institution, give street and number)

17030 Downing Street

4b. City, Town, or Location of Death

Gaithersburg

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

444-24-4513

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Dec. 12, 1921

9. Birthplace (State or Foreign Country)

Oklahoma

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Gaithersburg

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

17030 Downing Street

10f. Zip Code

20877

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

House Keeper

16b. Kind of Business/Industry

Cleaning

17. Father's Name (First, Middle, Last)

Frank Washington

18. Mother's Name (First, Middle, Maiden Surname)

Litha Pennington

19a. Informant's Name/Relationship (Type, Print)

Judith Ann Tippet, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

803 Quince Orchard Blvd. #21, Gaithersburg, MD 20878

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Gate Of Heaven Cemetery 7/25/97

Data

20c. Location - City or Town, State

Silver Spring, Maryland

21. Signature of Funeral Service Licensee

Michael D. Gibbons

22. Name and Address of Facility

DeVol Funeral Home  
10 East Deer Park Drive  
Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. PNEUMONIA

Due to (or as a consequence of):

b. SEPSIS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter underlying cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

4 days

2 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Abeda Ali Khan M.D.

29c. License number

D 43323

29d. Date signed (Month, Day, Year)

JULY 23, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ABEDA ALI KHAN

18111 PRINCE PHILIP DRIVE, OLNEY MD 20832

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

Julia Davidson-Randall

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23800

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

AGAPITA C. PARINASAN

2. Date of Death

July 18 1997

Day Year

3. Time of Death

7:30 PM

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

378-76-5531

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 15, 1915

9. Birthplace (State or Foreign Country)

Philippines

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Wheaton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3319 Pendleton Drive

10f. Zip Code

20902

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Asian

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
0

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Alipio Parinasan

18. Mother's Name (First, Middle, Maiden Surname)

Maria Cabornay

19a. Informant's Name/Relationship (Type, Print)

Dolores Ramia

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3319 Pendleton Drive, Wheaton, MD 20902

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mabolo Romano Cemetery

Date

8/1/97

20c. Location - City or Town, State

Cebu City, Philippines

21. Signature of Funeral Service Licensee

Tracy A. Shuman

22. Name and Address of Facility

Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

a. ACUTE MYOCARDIAL INFARCTION  
Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

2 days

Immediate Cause (Final disease or condition resulting in death)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMONARY EDEMA

HYPERTENSION

CHRONIC OBSTRUCTIVE LUNG DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Signature and title of certifier

Tracy A. Shuman MD

29d. License number

D 28656

29e. Date signed (Month, Day, Year)

JULY, 19, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAVI PASSI MD, 8609 SECOND AVE, #404 B, S. SPRING, MD 20910

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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Physician  
/Medical  
Examiner

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To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23801  
Certificate of Death

Reg. No.

|   |   |   |   |  |   |  |  |   |
|---|---|---|---|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Dorothy A. Pappas</b>  |   |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>16</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>4:45 pm</b>   |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Fairland Adventist Nursing &amp; Rehab. Center</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>  |  | 4c. County of Death<br><b>Montgomery</b>   |   |
| Funeral<br>Director   | 5. Social Security Number<br><b>322-12-8673</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>7/30/20</b>  | 9. Birthplace (State or Foreign Country)<br><b>Illinois</b> |
|   | Usual Residence of Decedent   |   |   |  |   |  |  |   |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Montgomery</b>  |   | 10c. City, Town or Location<br><b>Takoma Park</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>7051 Carroll Avenue, #1206</b>   |   |   |   | 10f. Zip Code<br><b>20912</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+) <b></b>   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Secretary</b>  |   |  | 16b. Kind of Business/Industry<br><b>Federal Government</b>                                    |   |
| 17. Father's Name (First, Middle, Last)<br><b>Charles W. Anderson</b>   |   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cordelia Cook</b>   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Richard Pappas</b>   |   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>721 Ritchie Avenue, Silver Spring, MD 20910</b> |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Ft. Lincoln Cemetery</b>   |  | Date<br><b>7/22/97</b>  |  | 20c. Location - City or Town, State<br><b>Brentwood, MD</b>                                    |   |
| 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>   |   |   |   |  | 22. Name and Address of Facility<br><b>Alexander S. Pope Funeral Homes</b><br><b>11315 Lockwood Drive, Silver Spring, MD 20904</b>                  |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |   |  |  |   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>METASTATIC RENAL CARCINOMA</b><br>Due to (or as a consequence of):<br>b. _____<br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____   |   |   |   |  |   |  |  |   |
| 23a. Part II. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |   |   |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|   |   |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|   |   |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   |   |   | 28d. Describe how injury occurred   |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |
|   |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. |   |   |   |  |   |  |  |   |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |   |   |  | 29c. License number<br><b>D36192</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 18, 1997</b>                                    |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>ANEES AHSAH - 7610 CARROLL AVE. SUITE 380, TAKOMA PARK, MD 20912</b>   |   |   |   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 21 1997</b>   |   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23802

Items: 23a part I, 27 per MEO G-750 8/11/97 dh  
GABRIEL PLATER

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GABRIEL CEDRIC PLATER</b>   |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>19</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>2:14 PM</b>   |  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>  |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                                     |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-86-3309</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>24</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPT. 28, 1972</b>                     |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>ST. MARY'S</b>   |  | 10c. City, Town or Location<br><b>MECHANICSVILLE</b>                             |  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>27195 TINTOP SCHOOL ROAD</b>   |  | 10f. Zip Code<br><b>20659</b>  |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>                            |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1990-1994</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>          |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>2 YEARS</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STUDENT / GROUP LEADER</b>  |  | 16b. Kind of Business/Industry<br><b>EDUCATION / CHILD CARE</b>  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>THOMAS TORELL PLATER</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SHELIA DIANE THOMPSON BUTLER</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>SHELIA D. BUTLER / MOTHER</b>   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>27195 TINTOP SCHOOL ROAD, MECHANICSVILLE, MD. 20659</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND VETERAN CEMETERY</b>   |  | 20c. Location - City or Town, State<br><b>CHELTENHAM, MARYLAND</b>               |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Lydia C. Thornton Johnson</i><br><b>LYDIA C. THORNTON JOHNSON M00583</b>   |  | 22. Name and Address of Facility<br><b>THORNTON FUNERAL HOME, P.A.<br/>3439 LIVINGSTON ROAD, INDIAN HEAD, MD. 20640</b>   |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>MULTIPLE SCLEROSIS</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  | 29b. Signature and title of certifier<br><i>Dennis J. Chute</i><br><b>Dennis J. Chute MD</b>   |  |
|   | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 20, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>                                 |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>  |  | 32. Registrar's Signature<br><i>Julia Anderson Randall</i>  |  |  |  |  |  |  |
|   |  |  |   |  |  |  |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23803

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |   |  |   |  |  |
|---|---|--|---|---|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ELIZABETH ELVIRA PUMPHREY</b>                          |  |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>22</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:40PM</b>   |  |   |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Physicians Memorial Hospital</b> |  |   |   | 4b. City, Town, or Location of Death<br><b>La Plata</b>  |  | 4c. County of Death<br><b>Charles</b>   |  |   |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-36-3498</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br><b>FEBRUARY 19, 1905</b>                             |  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b> |  |  |
|   | Usual Residence of Decedent   |  |   |   |  |  |   |  |   |  |  |
| 10a. State<br><b>MARYLAND</b>   |   |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |   | 10c. City, Town or Location<br><b>UPPER MARLBORO</b>   |  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |
| 10e. Street and Number<br><b>14205 OLD MARLBORO PIKE</b>  |   |  |   | 10f. Zip Code<br><b>20772</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b> |   |  |   |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>4</b>  |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b> |  |  | 16b. Kind of Business/Industry<br><b>EDUCATION</b>  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>RICHARD ERNEST SMITH</b>  |   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LAVINIA M. B. WILSON</b>   |  |   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ELIZABETH A. THORN/DAUGHTER</b>  |   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>14205 OLD MARLBORO PIKE, UPPER MARLBORO, MD 20772</b>                                    |  |   |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY EPISCOPAL CHURCH CEMETERY</b>  |   |  | Data<br><b>7/25/1997</b>                       |   | 20c. Location - City or Town, State<br><b>UPPER MARLBORO, MARYLAND</b>                         |   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>JPK MARK G. BROHAWN MO0053</b>  |   |  | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604</b>   |   |  |  |   |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>SEPSIS</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</b><br><b>DEMENTIA</b> |   |  |   |   |  |  |   |  |   | Approximate Interval Between Onset and Death<br><b>FEW DAYS</b>  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |   |  |   |   |  |  |   |  |   |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |   |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred                           |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  | 29b. Signature and title of certifier<br><b>Attenidny</b>   |   |  | 29c. License number<br><b>D-44436</b>          |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 23 1997</b>                                     |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ashvinkumar J. Patel, MD 603 Post Office Road Suite 207 Waldorf, Maryland 20602</b>  |   |  |   |   |  |  |   |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>   |   |  | 32. Registrar's Signature<br><b>John Andrew Randall</b>   |   |  |  |   |  |   |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.(Elizabeth Pumphrey)  
Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23804

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN WESLEY PINKNEY JR.</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>July 20, 1997</b>   |  | 3. Time of Death<br><b>2:00 a.m.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>230 Dodson Ave.</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>St. Michaels</b>  |  | 4c. County of Death<br><b>Talbot</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>212-18-6868</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 4, 1923</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Talbot</b>   |  | 10c. City, Town or Location<br><b>St. Michaels</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 10e. Street and Number<br><b>230 Dodson Ave.</b>  |  | 10f. Zip Code<br><b>21663</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+)   |   | 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Maintenance</b>                   |  | 16b. Kind of Business/Industry<br><b>Wheaton Plaza</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>John W. Pinkney Sr.</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Cornelia Bailey</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary T. Farmer Sister</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>230 Dodson Ave. St. Michaels, Maryland 21663</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Thomas Memorial Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>St. Michaels, Maryland</b>   |  | Date<br><b>July 25, 1997</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Harrison E. Leonard</i>   |   | 22. Name and Address of Facility<br><b>Harrison E. Leonard Funeral Home<br/>312 S. Talbot St. St. Michaels, Maryland 21663</b>                    |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Gastric Carcinoma</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |   |   |  |  |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anemia, Malnutrition, Hypertension</b>   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i>   |   |   |   | 29c. License number<br><b>D47492</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/22/97</b>                            |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Jeffrey T. Denton, MD Rt 313 Goldsboro, Maryland 21636</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>   |   | 32. Registrar's Signature<br><i>[Signature]</i>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23805

## Certificate of Death

Reg. No.

|   |   |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|---|---|--|---|--------------------------------|--|--|--|--|--|----------|---|-----------------------------|--|--|--|--|--|--|--|----------|----------------------------------|--|--|--|--|--|--|--|--|--|---------------|--|--|--|--|--|--|--|----------|----------------------------------|--|--|--|--|--|--|--|--|---------------------|--|--|--|--|--|--|--|---------|----------------------------------|--|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Lorraine Penland  |  |   |                                | 2. Date of Death<br>Month Day Year<br>July 12 1997   |  |  |  | 3. Time of Death<br>7:30 AM  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br>Deer's Head Center  |  |   |                                | 4b. City, Town, or Location of Death<br>Salisbury  |  |  |  | 4c. County of Death<br>Wicomico  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br>106-12-8654  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                                | 7. Age (In yrs. last birthday)<br>87 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>FEB. 5, 1910          |  | 9. Birthplace (State or Foreign Country)<br>UNKNOWN  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | Usual Residence of Decedent   |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10e. State<br>MARYLAND  |  | 10b. County<br>WICOMICO   |                                | 10c. City, Town or Location<br>SALISBURY   |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 10e. Street and Number<br>351 DEER'S HEAD HOSPITAL ROAD   |  |   |                                | 10f. Zip Code<br>21802   |  | 10g. Citizen of What Country?<br>USA                         |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 11 College (14 or 5+)  |  |   |                                | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>UNKNOWN   |  |  | 16b. Kind of Business/Industry   |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>UNKNOWN  |  |   |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br>UNKNOWN   |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br>SANDRA REYNOLDS/SOCIAL WORKER   |  |   |                                | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>351 DEER'S HEAD HOSPITAL ROAD, SALISBURY, MD 21802  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>JERUSALEM CEMETERY  |                                | Date<br>7/18/97  |  | 20c. Location - City or Town, State<br>PARSONSBURG, MARYLAND |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |                                | 22. Name and Address of Facility<br>ZELLER FUNERAL HOME, P. O. BOX 3171,<br>1212 OLD OCEAN CITY ROAD, SALISBURY, MD 21802  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">e. Congestive Heart Failure</td> <td>48 Hours</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="8">b. Septicemia</td> <td>60 Hours</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">c. Dental Abscesses</td> <td>1 Month</td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td colspan="8">d.</td> <td></td> </tr> </table> |  |   |                                |  |  |  |  |  |          | Immediate Cause (Final disease or condition resulting in death) | e. Congestive Heart Failure |  |  |  |  |  |  |  | 48 Hours | Due to (or as a consequence of): |  |  |  |  |  |  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. Septicemia |  |  |  |  |  |  |  | 60 Hours | Due to (or as a consequence of): |  |  |  |  |  |  |  |  | c. Dental Abscesses |  |  |  |  |  |  |  | 1 Month | Due to (or as a consequence of): |  |  |  |  |  |  |  |  | d. |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   | e. Congestive Heart Failure   |  |   |                                |  |  |  |  | 48 Hours   |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | Due to (or as a consequence of):  |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. Septicemia  |   |                                |  |  |  |  |  | 60 Hours |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   |   | Due to (or as a consequence of):   |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| c. Dental Abscesses   |   |  |   |                                |  |  |  | 1 Month  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| Due to (or as a consequence of):  |   |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| d.  |   |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>Senile Dementia   |   |  |   |                                |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   |   |  |   |                                |  |  |  | 24e. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   |   |  |   |                                |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br>M       |  | 28c. Injury et Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |                                |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |  |   | 29c. License number<br>D 33905 |  | 29d. Date signed (Month, Day, Year)<br>7/12/97                                       |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>V.A. Dulany, M.D., CMD; P.O. BOX 2018; Salisbury, Md. 21802   |   |  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 28 1997  |   | 32. Registrar's Signature<br>  |   |                                |  |  |  |  |  |          |   |                             |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |  |               |  |  |  |  |  |  |  |          |                                  |  |  |  |  |  |  |  |  |                     |  |  |  |  |  |  |  |         |                                  |  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |




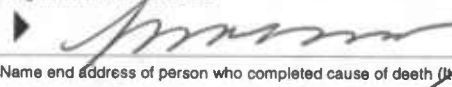

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23806

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |   |  |  |   |  |
|---|--|--|---|--|--|--|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>GLADYS MAE LYNCH</b>  |  |   |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>03</b> Year <b>1997</b>   |  |  |   | 3. Time of Death<br><b>9:45 PM</b>   |  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Berlin Nursing Home</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Berlin</b>  |  |  |   | 4c. County of Death<br><b>Worcester</b>  |  |   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>222-22-4986</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>6/30/13</b>                                |   | 9. Birthplace (State or Foreign Country)<br><b>DE</b>  |  |   |  |
|   | Usual Residence of Decedent  |  |   |  |  |  |  |   |  |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Worcester</b>   |  | 10c. City, Town or Location<br><b>Berlin</b>   |  |  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
|   | 10e. Street and Number<br><b>10816 Adkins RD</b>   |  |   |  | 10f. Zip Code<br><b>21811</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b> |  |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br><b>2</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>School Teacher</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Education</b>                                   |   |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Archie J. Lynch</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cleora Donoway</b>   |  |  |   |  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Paula Jones/ Daughter</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10816 Adkins RD Berlin, MD 21811</b>   |  |  |   |  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Evergreen Cemetery</b>   |  | 20c. Date<br><b>7/7/97</b>   |  | 20d. Location - City or Town, State<br><b>Berlin, MD</b>                             |   |  |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>Burbage Funeral Home<br/>108 William St. Berlin, MD 21811</b>   |  |  |   |  |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>congestive Heart Failure</b><br>Due to (or as a consequence of):<br>f. <b>Coronary Artery Disease</b><br>Due to (or as a consequence of):<br>g. <b>Diffuse Atherosclerosis</b><br>Due to (or as a consequence of):<br>h.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |  |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>Months.</b><br><b>Years.</b>   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Recent Pneumonia</b><br><b>Clotridium difficile 14/0.</b>   |  |   |  |  |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |   |  |  |   |  |
|   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |   |  |
| State Registrar                               | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |  |   |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D02026</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>John R. G. Arthes</b>                      |   |  |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>FEDERICO G. ARTHES, MD 1622A OCEAN PINES BERLIN MD 21811</b>  |  |   |  |  |  |  |   |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>AUG 05 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |  |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23807

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sanford Herman Rager

2. Date of Death

Month Day Year  
July 24, 1997

3. Time of Death

4:00 am

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

170-18-0151

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 2, 1903

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel

10c. City, Town or Location

Davidsonville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2519 Cheval Drive

10f. Zip Code

21035-1129

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Plasterer

16b. Kind of Business/Industry

Ohio School Board

17. Father's Name (First, Middle, Last)

Harry Rager

18. Mother's Name (First, Middle, Maiden Surname)

Ellen Ford

19a. Informant's Name/Relationship (Type, Print)

Bruce W. Rager - Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2519 Cheval Drive, Davidsonville, Maryland 21035

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Tod Homestead Cemetery

Date

07/29/97

20c. Location - City or Town, State

Youngstown, Ohio

21. Signature of Funeral Service Licensee

► Claudette L. Dasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.  
4739 Baltimore Avenue, Hyattsville, MD 2078123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Pneumonia

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Days

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

► [Signature]

29c. License number

D41978

29d. Date signed (Month, Day, Year)

July 25, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Tavakoli 3001 Hospital Drive, Cheverly, Maryland 20785

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23808

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wanda A. Robinson

2. Date of Death

Month  
July 18, 1997

3. Time of Death

9:00 PM

4a. Facility Name (If not institution, give street and number)

Prince George's Hospital Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-70-1983

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

December 4, 1951

9. Birthplace (State or Foreign Country)

South Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Palmer Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8000 Sheriff Road

10f. Zip Code

20785

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Computer Analyst

16b. Kind of Business/Industry

Basil/Voger Insurance

17. Father's Name (First, Middle, Last)

Theodore Allen

18. Mother's Name (First, Middle, Maiden Surname)

Helen C. Precia

19a. Informant's Name/Relationship (Type, Print)

Mr. Ozell E. Robinson, Jr. (Husband)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8000 Sheriff Road Palmer Park, Maryland 20785

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Chesapeake Crematory, Inc.

Date

7/21/97

20c. Location - City or Town, State

Beltsville, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rollins Funeral Home, Inc.

4339 Hunt Place, N.E. Washington, D.C. 20019

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Stroke, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Cerebral hemorrhage

Due to (or as a consequence of):

metastatic Breast Cancer

Due to (or as a consequence of):

metastatic Cancer to the Brain

Due to (or as a consequence of):

metastatic Cancer to the Lungs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical

examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Signature and title of certifier

29e. License number

29f. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Willie C. Bittler 7525 Greenway Center Suite 211 Greenbelt

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

John Davidson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

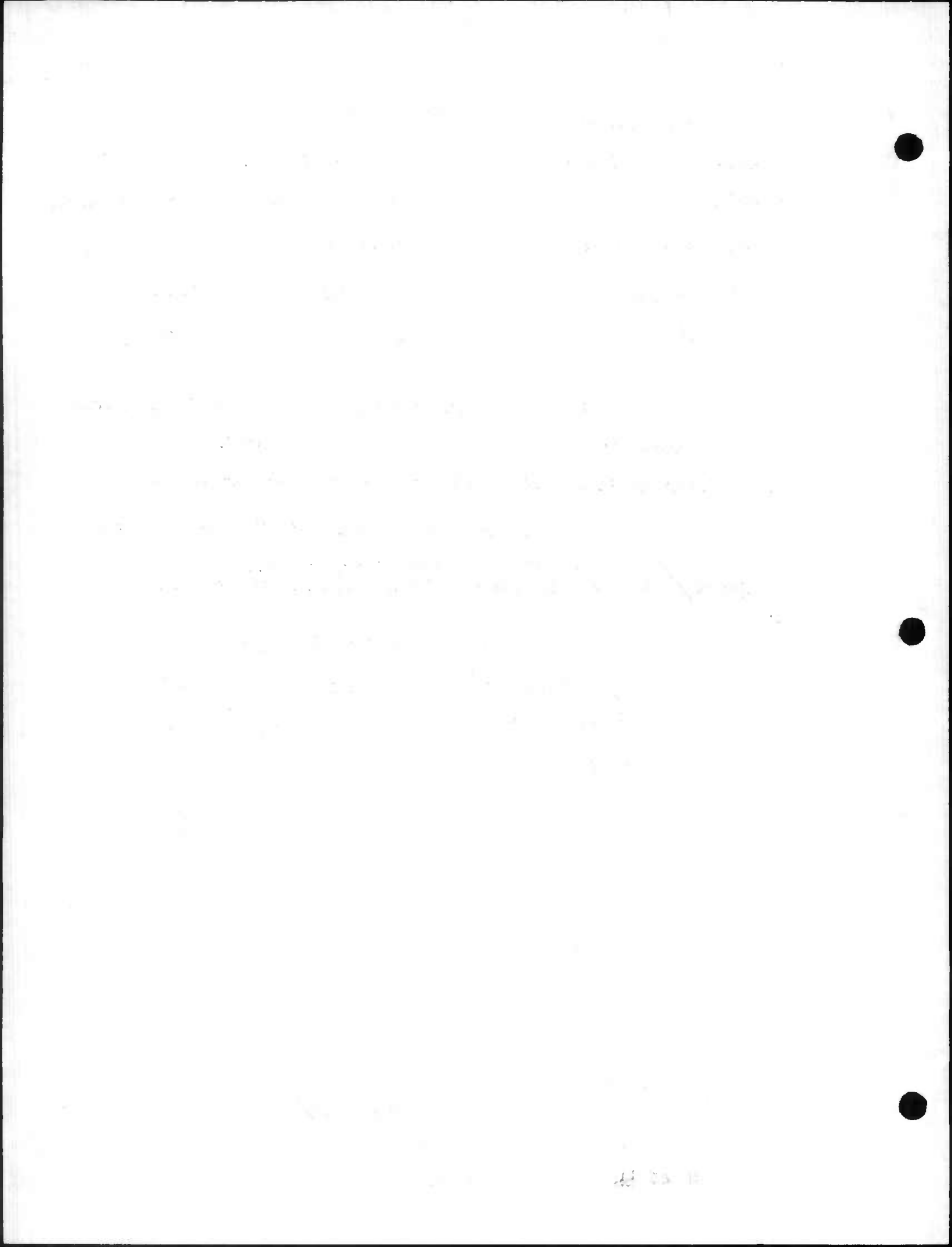
Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23809

|  |  |   |   |  |  |   |  |  |
|--|--|---|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James Rustin</b>  |   |   |  | 2. Date of Death<br>Month Day Year<br><b>07-16-97</b>  |   | 3. Time of Death<br><b>8:00 PM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4711 Berwyn House Road #201</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>College Park</b>  |   | 4c. County of Death<br><b>Prince George's</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-38-4263</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>06-27-21</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>  |   | 10c. City, Town or Location<br><b>College Park</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>4711 Berwyn House Road #201</b>  |  | 10f. Zip Code<br><b>20741</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>11-4-42 12-31-45</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th</b><br>College (1-4or 5+) <b>College</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Worker</b>                                   |  | 16b. Kind of Business/Industry<br><b>Private</b>   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>David Rustin</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Cora (Unknown)</b>   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Bernice Rustin/Wife</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4711 Berwyn House Road #201, College Park, MD 20741</b>                                  |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Maryland Veteran's Cem.</b>  |  | Date<br><b>7/21/97</b>   |   | 20c. Location - City or Town, State<br><b>Cheltenham, Maryland</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>J.B. Jenkins Funeral Home<br/>7474 Landover Road, Landover, MD 20785</b>  |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Lung carcinoma with cerebral metastasis</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>2 years</b> |   |   |  |  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Diabetes mellitus Type II</b><br><b>Atherosclerotic vascular disease</b>  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No                        |  |  |   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |  |   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |   |  |  |
| 29b. Signature and title of certifier<br>  |  |   |   | 29c. License number<br><b>022780</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/18/97</b>                                       |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Peter M. Schissler MD 7500 Greenway Chr Dr. Greenbelt Md 20770</b>  |  |   |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 21 1997</b>  |  | 32. Registrar's Signature<br>   |   |  |  |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

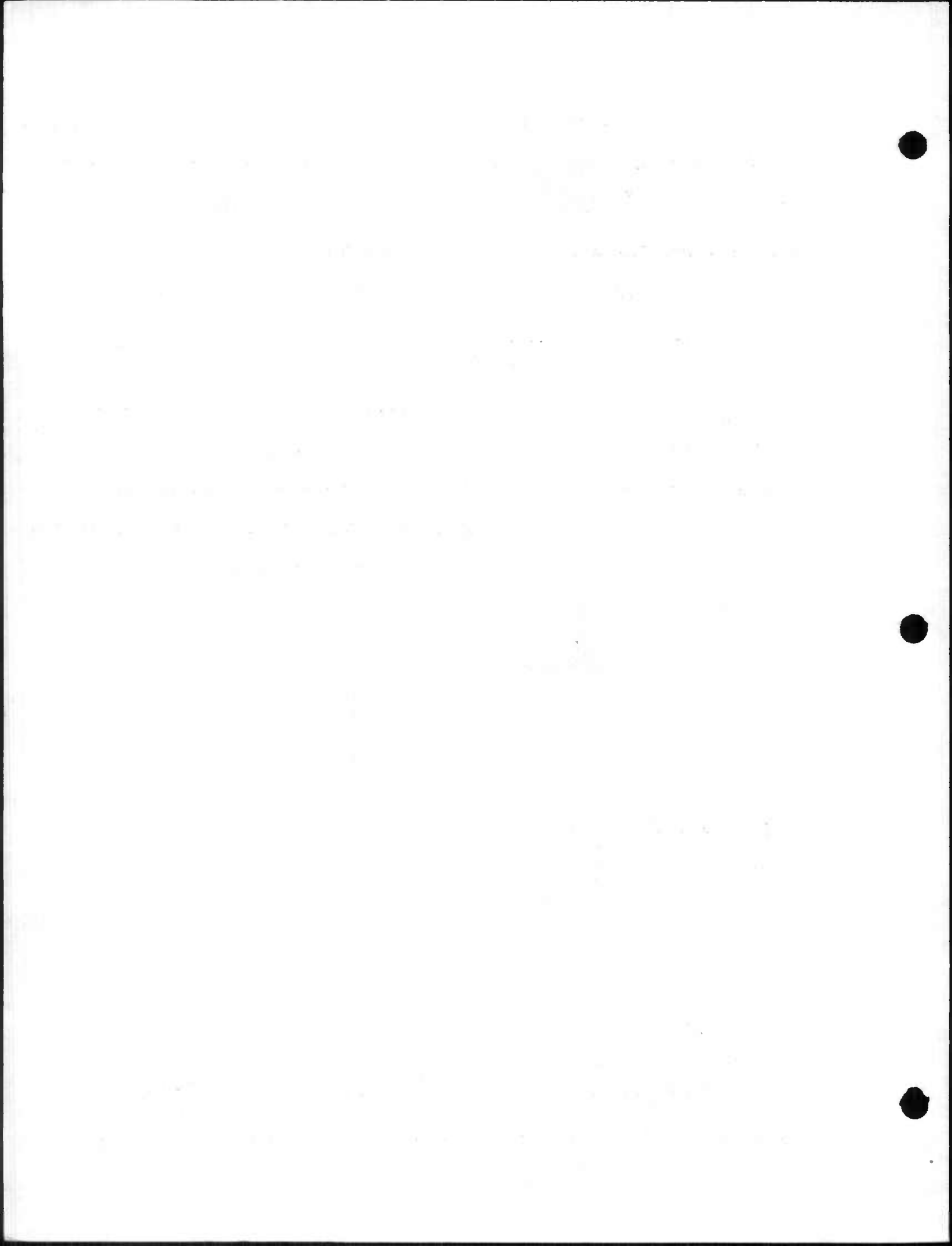
Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23810

AMENDED # 5. P.G.C. 7-23-97 cr

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard C. Richardson SR.

2. Date of Death

Month July Day 19 Year 1997

3. Time of Death

8:00 pm

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

577-18-0060

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month 4 Day 27 Year 1918

9. Birthplace (State or Foreign Country)

VIRGINIA

10a. State

DC

10b. County

N/A

10c. City, Town or Location

WASHINGTON

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

732 EMERSON STREET NE

10f. Zip Code

20017

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

8TH GRADE

College (1-4 or 5+)

NONE

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

FEDERAL GOVERNMENT EMPLOYEE

16b. Kind of Business/Industry

FEDERAL GOVERNMENT

17. Father's Name (First, Middle, Last)

AMON G. RICHARDSON

18. Mother's Name (First, Middle, Maiden Surname)

HATTIE M. FLETCHER

19a. Informant's Name/Relationship (Type, Print)

RICHARD C. RICHARDSON JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS 10A, B, C, D, E, &amp; F

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK

Date

7/24/97

20c. Location - City or Town, State

LANDOVER, MD.

21. Signature of Funeral Service Licensee

Juan D. Smith

22. Name and Address of Facility

JOHN T. RHINES CO., INC.

3030 12TH ST NE, DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. atherosclerotic heart disease years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation2 ☐ Accident 6 ☐ Could not be determined3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John F. Tauber MD

29c. License number

D08546

29d. Date signed (Month, Day, Year)

July 20 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John F. Tauber 8218 Wisconsin Ave Bethesda MD

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

7/23/97 Discussed with Diana Barbour

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23811

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |  |  |   |                                 |   |  |
|---|--|--|--|---|---------------------------------|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Ivor Rose</b>  |  |  |  | 2. Date of Death<br>Month: <b>07</b> Day: <b>20</b> Year: <b>97</b>   |                                 | 3. Time of Death<br><b>4:50PM</b>   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>4865 ST. BARNABAS RD.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>TEMPLE HILLS</b>   |                                 | 4c. County of Death<br><b>PRINCE GEORGE'S</b>   |  |
| 5. Social Security Number<br><b>063-38-4399</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs. | If Under 1 Year<br>Months: Days:  | If Under 24 Hrs.<br>Hours: Min. | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 3, 1944</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>KINGSTON, JAMAICA</b>  |  |  |  |   |                                 |   |  |
| 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>PRINCE GEORGE'S</b>  |  | 10c. City, Town or Location<br><b>HILLSIDE</b>  |                                 | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |  |
| 10e. Street and Number<br><b>1907 BROOKS DR. #104</b>   |  |  |  | 10f. Zip Code<br><b>20743</b>   |                                 | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:     |                                 | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12): <b>12</b><br>College (1-4 or 5+):   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PROFESSIONAL DRIVER</b>  |  | 16b. Kind of Business/Industry<br><b>GOVERNMENT</b>   |                                 |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOHN ROSE</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MONICA MARR</b>   |                                 |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>PATRICIA ROSE/ WIFE</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1907 BROOKS DR. #104 HILLSIDE, MARYLAND 20743</b> |                                 |   |  |
| 20a. Method of Disposition<br><b>1</b> Burial - <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>HARMONY MEMORIAL PARK</b>   |  | Data<br><b>7/28/97</b>  |                                 | 20c. Location - City or Town, State<br><b>LANDOVER, MARYLAND</b>  |  |
| 21. Signature of Funeral Service Licensee<br><i>Keith A. Sarge M1085</i>  |  |  |  | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES<br/>5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747</b>                         |                                 |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>e. METASTATIC ADENOCARCINOMA OF LUNG</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |  |  |  |   |                                 | Approximate Interval Between Onset and Death<br><b>7 MONTHS</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |                                 | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown |  |
| 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No  |  |  |  |   |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No               |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |  |   |                                 |   |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending Investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |                                 | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |                                 |   |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Howard Tracer M.D.</i>   |  | 29c. License number<br><b>D41823</b>  |                                 | 29d. Date signed (Month, Day, Year)<br><b>7/21/97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>HOWARD TRACER, M.D. 8300 CORPORATE DR. LANDOVER, MARYLAND 20785</b>  |  |  |  |   |                                 |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>   |  | 32. Registrar's Signature<br><i>John Anderson-Rodell</i>   |  |   |                                 |   |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-d show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23812

Amended #20b, 20c, 7/21/97, JW, Montg. Cty. Certificate of Death

Reg. No.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>Ellen Beth Ross   |   | 2. Date of Death<br>Month: July Day: 14, 1997 Year: 1997   |   | 3. Time of Death<br>1:50PM   |
|   | 4a. Facility Name (If not institution, give street and number)<br>6925 PERSIMMON TREE LANE  |   | 4b. City, Town, or Location of Death<br>BETHESDA   |   | 4c. County of Death<br>MONTGOMERY  |
| Funeral<br>Director   | 5. Social Security Number<br>549-90-9614  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>40 Yrs.  | 8. Date of Birth (Month, Day, Year)<br>AUG. 1, 1956 | 9. Birthplace (State or Foreign Country)<br>NEW YORK   |
|   | Usual Residence of Decedent   |   | 10a. State<br>MARYLAND   |   | 10b. County<br>MONTGOMERY  |
| To Be Completed by Funeral Director   | 10c. City, Town or Location<br>BETHESDA   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |
|   | 10e. Street and Number<br>6925 PERSIMMON TREE ROAD  |   | 10f. Zip Code<br>20817   |   | 10g. Citizen of What Country?<br>UNITED STATES   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) _____ College (1-4 or 5+) 5+  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>LAWYER  |
|   | 16b. Kind of Business/Industry<br>SEC ENFORCEMENT LAWYER  |   | 17. Father's Name (First, Middle, Last)<br>ALAN ROSS   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>VIVIAN SCHNEIDER  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br>D. ANNETTE FIELDS   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6925 PERSIMMON TREE RD., BETHESDA, MD 20817   |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>HILLSIDE MEMORIAL PARK   |   | 20c. Location - City or Town, State<br>Los Angeles, CALIFORNIA   |
|   | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.<br>1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. METASTATIC BREAST CANCER<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br>6 MONTHS   |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M 28c. Injury at Work? 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                   |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br>   |  | 29c. License number<br>11506                        |  |
| 29d. Date signed (Month, Day, Year)<br>7-15-97  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>DR. FREDERICK PEARSON SMITH, 5401 WESTERN AVENUE, NW, WASHINGTON, DC 20015-2998   |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 21 1997  |   | 32. Registrar's Signature<br>   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23813

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Marcelle O'Shaughnessy Rivello

2. Date of Death

Month Day Year  
July 23, 1997

3. Time of Death

6:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

8502 Hunter Creek Terrace

4b. City, Town, or Location of Death

Potomac

4c. County of Death

Montgomery

5. Social Security Number

578-26-8570

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb. 17, 1923

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8502 Hunter Creek Terrace

10f. Zip Code

20854

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

John King O'Shaughnessy

18. Mother's Name (First, Middle, Maiden Surname)

Frances Hochette

19a. Informant's Name/Relationship (Type, Print)

David M. Rivello/ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1808 E. Clear Lake Drive, Salisbury, Maryland 21804

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery

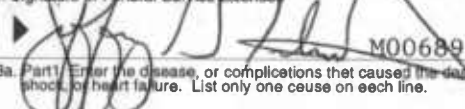
Date

July 29, 1997

20c. Location - City or Town, State

Arlington, Virginia

21. Signature of Funeral Service Licensee



22. Name and Address of Facility Robert A. Pumphrey Funeral Home/

Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue,

Bethesda, Maryland 20814-3501

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

shock, or heart failure. List only one cause on each line.

Approximate

Interval Between

Onset and Death

Immediate Cause (Final

disease or condition

resulting in death)

e. Emphysema

10 Years

Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Polycythemia

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy

performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings

available prior to

completion of cause

of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical

examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office

building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State)

29a. Certifier

(Check only

one)

☒ **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33443

29d. Date signed (Month, Day, Year)

July 23, 1997

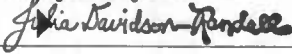
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Alan R. Pollack, M.D. 809 Veirs Mill Road, Rockville, Maryland 20851

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature


State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23814

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

ALVERTA

2. Date of Death

Month

Day

Year

3. Time of Death

11:45 PM

4a. Facility Name (If not institution, give street and number)

9944 Cottrell Terrace

4b. City, Town, or Location of Death

Silver Spring

4c. County of Death

Montgomery

5. Social Security Number

233-34-5499

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

74 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Days

Hours

Min.

8. Date of Birth

(Month, Day, Year)

Oct. 28, 1922

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9944 Cottrell Terrace

10f. Zip Code

20903

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Private Practice

17. Father's Name (First, Middle, Last)

Esty Richards

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude Moats

19a. Informant's Name/Relationship (Type, Print)

James E. Ridgely / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15010 Elmcrest Street, Odessa, Florida 33556

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Fort Lincoln Crematory

Date

7/22/97

20c. Location - City or Town, State

Brentwood, Maryland

21. Signature of Funeral Service Licensee

Thomas J. Jurek

22. Name and Address of Facility Hines-Rinaldi Funeral Home

11800 New Hampshire Avenue

Silver Spring, Maryland 20904

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Tauler

29c. License number

DOE546

29d. Date signed (Month, Day, Year)

July 19 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tauler

8218 Wisconsin Ave Bethesda

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



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State of Maryland / Department of Health and Mental Hygiene

97 23815

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Ray R. Rew</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>8:30A.</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>11803 Macon Street</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Beltsville</b>  |  | 4c. County of Death<br><b>Prince George's</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>540-18-5617</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>75</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 20, 1922</b>                                |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Colorado</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Prince George's</b>  |  | 10c. City, Town or Location<br><b>Beltsville</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>11803 Macon Street</b>   |  | 10f. Zip Code<br><b>20705</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                       |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1959-1963</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Lab Technician</b>  |  | 16b. Kind of Business/Industry<br><b>United States Navy</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Ralph M. Rew</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Bessie Helen Denny</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mark B. Rew (son)</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15700 Easthaven Court Bowie, Maryland 20716</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Market Cemetery</b>  |  | Date<br><b>7/23/1997</b>   |  | 20c. Location - City or Town, State<br><b>New Market, Maryland</b>                          |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Donald V. Borgwardt</b>   |  |   |  | 22. Name and Address of Facility<br><b>Donald V. Borgwardt Funeral Home, P.A.<br/>4400 Powder Mill Rd. Beltsville, Maryland 20705</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br>a. _____<br>b. _____<br>c. _____<br>d. _____<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |   | Approximate Interval Between Onset and Death   |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Emphysema</b>  |  |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>024283-</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 21, 1997</b>  |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Muhammad Yusuf, M.D. 3450 Ft. Meade Road, #105 Laurel, Maryland 20724-2040</b>   |  |   |  |  |  |   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23816

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SHARON LEE RATCLIFFE

2. Date of Death

Month Day Year  
July 26 1997

3. Time of Death

2:50 pm

4a. Facility Name (If not institution, give street and number)

3645 Karen Circle

4b. City, Town, or Location of Death

Linkwood

4c. County of Death

Dorchester

5. Social Security Number

217-44-1524

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

49

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

May 20 1948

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Dorchester

10c. City, Town or Location

Linkwood

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3645 Karen Circle

10f. Zip Code

21835

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: white

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

group leader, assembly line

16b. Kind of Business/Industry

electronics mfg.

17. Father's Name (First, Middle, Last)

Thomas H. Hurley

18. Mother's Name (First, Middle, Maiden Surname)

Mary Rosetta

19a. Informant's Name/Relationship (Type, Print)

Ms. Kimberly Ratcliffe-daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3645 Karen Circle, Linkwood, MD 21835

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dorchester Memorial Park

Date

7-29-97

20c. Location - City or Town, State

Cambridge, Maryland

21. Signature of Funeral Service Licensee

Kenneth R. Thomas Jr.

22. Name and Address of Facility

Thomas Funeral Home PA  
700 Locust St., Cambridge MD 2161323a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Metastatic small cell carcinoma of lung

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

16 months

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☒ Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mary Ann D. Moore MD

29c. License number

D31766

29d. Date signed (Month, Day, Year)

7/28/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

408 Byrn St, Cambridge, MD 21613

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

John Andrew Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





**Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.**  
**State of Maryland / Department of Health and Mental Hygiene**  
**Certificate of Death**

Reg. No. **97 23817**

**Physician  
/Medical  
Examiner**

**Funeral  
Director**

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Bernice Valentine Reiher</b>  |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>24</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>12:00 PM</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>40937 Lake &amp; Breton View Drive</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>  |  | 4c. County of Death<br><b>St. Mary's</b>   |  |
| 5. Social Security Number<br><b>321-18-0353</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>February 3, 1917</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>Illinois</b>  |  |   |  |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>St. Mary's</b>  |  | 10c. City, Town or Location<br><b>Leonardtown</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>40937 Lake &amp; Breton View Drive</b>  |  |   |  | 10f. Zip Code<br><b>20650</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-1945</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Civil Servant</b>   |  | 16b. Kind of Business/Industry<br><b>Defense</b>  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Soren Sandnes</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rosina Johansson</b>  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>John R. Reiher, Husband</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>40937 Lake &amp; Breton View Drive, Leonardtown, MD 20650</b>                             |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | Date<br><b>7/24/97</b>  |  | 20c. Location - City or Town, State<br><b>Alexandria, Virginia</b>   |  |
| 21. Signature of Funeral Service Director<br><br><b>Michael K. Blankenship</b>   |  |   |  | 22. Name and Address of Facility<br><b>Brinsfield Funeral Home, P.A.<br/>22955 Hollywood Road, Leonardtown, MD 20650</b>  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Acute Leukemia -</b><br/>Due to (or as a consequence of):</p> <p>b. Due to (or as a consequence of):</p> <p>c. Due to (or as a consequence of):</p> <p>d. Due to (or as a consequence of):</p> </div> <div style="width: 35%; text-align: center;"> <p>Approximate Interval Between Onset and Death</p> <p><b>8 mos.</b></p> </div> </div> |  |   |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>h/o breast cancer (no active disease)</b>   |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  | 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br><br><b>William K. Kelly</b>  |  |   |  | 29c. License number<br><b>D39979</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/24/97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>William K. Kelly MD. ST. MARY'S HOSPITAL LEONARDTOWN, MD. 20650</b>   |  |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>  |  |   |  | 32. Registrar's Signature<br><br><b>John Davidson-Randall</b>  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Bernice Reiher  
Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

**State  
Registrar**



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23818

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
|---|---|--|---|--|--|--|--|--|---|--|--|--|----------------|--|--------------|----|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><u>DODATITY SMITH</u>   |  |   |  | 2. Date of Death<br>Month <u>July</u> Day <u>17</u> Year <u>1997</u>   |  | 3. Time of Death<br><u>22:41</u>   |  |   |  |  |  |                |  |              |    |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><u>JOHNS HOPKINS HOSPITAL</u>   |  |   |  | 4b. City, Town, or Location of Death<br><u>BALTIMORE</u>   |  | 4c. County of Death<br><u>Baltimore</u>                                  |  |   |  |  |  |                |  |              |    |  |
| Funeral<br>Director   | 5. Social Security Number<br><u>218-20-7264</u>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><u>72</u> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><u>December 26, 1924 Maryland</u> |  |   |  |  |  |                |  |              |    |  |
|   | Usual Residence of Decedent   |  | 10a. State<br><u>Maryland</u>   |  | 10b. County<br><u>Queen Annes</u>  |  | 10c. City, Town or Location<br><u>Crumpton</u>                           |  |   |  |  |  |                |  |              |    |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><u>204 3rd Street</u>   |  | 10f. Zip Code<br><u>21628</u>  |  | 10g. Citizen of What Country?<br><u>U.S.A.</u>                           |  |   |  |  |  |                |  |              |    |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <u>White</u>  |  |   |  |  |  |                |  |              |    |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><u>Homemaker</u>                     |  | 16b. Kind of Business/Industry<br><u>Domestic/Own Home</u>   |  |  |  |   |  |  |  |                |  |              |    |  |
|   | 17. Father's Name (First, Middle, Last)<br><u>Clarence Marvel</u>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><u>Mary Wellar</u>  |  |  |  |   |  |  |  |                |  |              |    |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><u>Franklin D. Smith/Husband</u>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><u>P. O. Box 32, Crumpton, Maryland 21628</u>   |  |  |  |   |  |  |  |                |  |              |    |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><u>Crumpton Cemetery/July 22, 1997</u>                                  |  | 20c. Location - City or Town, State<br><u>Crumpton, Maryland</u>   |  |  |  |   |  |  |  |                |  |              |    |  |
|   | 21. Signature of Funeral Service Licensee<br><u>[Signature]</u>   |  |   |  | 22. Name and Address of Facility<br><u>Fellows, Helfenbein &amp; Newnam Funeral Home, P.A.<br/>130 Speer Road, Chestertown, Maryland 21620</u>   |  |  |  |   |  |  |  |                |  |              |    |  |
|   | 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a. <u>SEPSIS</u><br/>Due to (or as a consequence of):</td> <td>Approximate interval between Onset and Death<br/><u>5 weeks</u></td> </tr> <tr> <td>b. <u>Ischemic colitis</u><br/>Due to (or as a consequence of):</td> <td><u>5 WEEKS</u></td> </tr> <tr> <td>c. <u>Vascular Insufficiency</u><br/>Due to (or as a consequence of):</td> <td><u>YEARS</u></td> </tr> <tr> <td>d.</td> <td></td> </tr> </table> |  |   |  |  |  |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. <u>SEPSIS</u><br>Due to (or as a consequence of): | Approximate interval between Onset and Death<br><u>5 weeks</u> | b. <u>Ischemic colitis</u><br>Due to (or as a consequence of): | <u>5 WEEKS</u> | c. <u>Vascular Insufficiency</u><br>Due to (or as a consequence of): | <u>YEARS</u> | d. |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a. <u>SEPSIS</u><br>Due to (or as a consequence of): | Approximate interval between Onset and Death<br><u>5 weeks</u>  |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| b. <u>Ischemic colitis</u><br>Due to (or as a consequence of):  |   | <u>5 WEEKS</u>                                       |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| c. <u>Vascular Insufficiency</u><br>Due to (or as a consequence of):  |   | <u>YEARS</u>   |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| d.  |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><u>Peripheral Vascular disease, Renal Artery Stenosis</u><br><u>Coronary artery disease; Chronic obstructive pulmonary disease; hypertension</u>  |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 28d. Describe how injury occurred<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 29b. Signature and title of certifier<br><u>[Signature]</u>   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 29c. License number<br><u>RES-000</u>   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 29d. Date signed (Month, Day, Year)<br><u>July 17, 1997</u>   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><u>JOHNS HOPKINS HOSPITAL</u><br><u>SHERRY L. JONES, MD 600 North Wolfe St Baltimore Maryland 21287</u>   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 31. Date filed (Month, Day, Year)<br><u>Jul 21 '97</u>  |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |
| 32. Registrar's Signature<br><u>[Signature]</u>   |   |  |   |  |  |  |  |  |   |  |  |  |                |  |              |    |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23819

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Vora F. Smith

2. Date of Death

Month

Day

Year

7

8

97

3. Time of Death

3:46 P.M.

4a. Facility Name (If not institution, give street and number)

P.G. Hospital

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

P.G.

Funeral  
Director

5. Social Security Number

UNKNOWN

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

4-28-1902

9. Birthplace (State or Foreign Country)

MASS

Usual Residence of Decedent

10a. State

MD

10b. County

P.G.

10c. City, Town or Location

Seat Pleasant

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

5737 MLK Jr. Ave

10f. Zip Code

20743

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Unknown

16b. Kind of Business/Industry

Unknown

17. Father's Name (First, Middle, Last)

Unknown

18. Mother's Name (First, Middle, Maiden Surname)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Shirley Bussie

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5606 Justin Dr. Seabrook, Md.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Harmony

Date

7-14-97

20c. Location - City or Town, State

Landover

21. Signature of Funeral Service Licensee

Dorice Edwards

22. Name and Address of Facility

Hodges + Edwards Seabrook, Md.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

sepsis

Approximate Interval Between Onset and Death

1 day

e. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

George C. Hajjar, Jr.

29c. License number

039550

29d. Date signed (Month, Day, Year)

7/9/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md. 20706

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

John Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Area 22.000 27.000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23820

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert H. Spottswood

2. Date of Death

Month  
JulyDay  
18,Year  
1997

3. Time of Death

4:45 pm

4a. Facility Name (If not institution, give street and number)

5521 Kennedy Street

4b. City, Town, or Location of Death

Riverdale

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

223-36-5000

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

July 14, 1934

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Riverdale

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5521 Kennedy Street

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No.  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

9

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Terminal Manager

16b. Kind of Business/Industry

Tanklines Trucking

17. Father's Name (First, Middle, Last)

Robert Garr Spottswood

18. Mother's Name (First, Middle, Maiden Surname)

Harriett Bartlett

19a. Informant's Name/Relationship (Type, Print)

Sarah Spottswood - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5521 Kennedy Street, Riverdale, Maryland 20737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fairview Cemetery

Date

07/21/97

20c. Location - City or Town, State

Culpeper, Virginia

21. Signature of Funeral Service Licensee

Claudette L. Gasch

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Metastatic Carcinoma  
Due to (or as a consequence of):Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

18 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstructive Pulmonary Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☒ Residence8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Gabriel Jaffe

29c. License number

D16410

29d. Date signed (Month, Day, Year)

July 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Gabriel Jaffe, M.D. 7500 Hanover Parkway #105, Greenbelt, Maryland 20770-2093

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Andrew Rask

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. After this certificate has been signed by the attending physician and to the Funeral Director. After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23821

Reg. No.

|  |   |   |  |   |  |  |  |   |
|--|---|---|--|---|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Edith Mae Jones Straughan                 |   |  |   | 2. Date of Death<br>Month Day Year<br>July 20 1997 |  | 3. Time of Death<br>2:20 P.M.                        |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br>9307 Calanda Street |   |  |   | 4b. City, Town, or Location of Death<br>Lanham     |  | 4c. County of Death<br>Prince George's               |   |
| Funeral<br>Director  | 5. Social Security Number<br>227 42 2309  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br>61 Yrs.   | If Under 1 Year<br>Months Days                     | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br>Jan. 23, 1936 | 9. Birthplace (State or Foreign Country)<br>Virginia  |
|  | Usual Residence of Decedent   |   |  |   |  |  |  |   |
| 10a. State<br>Maryland   |   | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Lanham   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |
| 10e. Street and Number<br>9307 Calanda Street  |   |   |  | 10f. Zip Code<br>20706  |  | 10g. Citizen of What Country?<br>United States   |  |   |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 3 Collega (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Registered Nurse   |  | 16b. Kind of Business/Industry<br>Health Care  |  |   |
| 17. Father's Name (First, Middle, Last)<br>Harrison E. Jones   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Linnie Barrett   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br>Orren C. Straughan Husband   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9307 Calanda Street Lanham Md. 20706   |  |  |  |   |
| 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Beulah Baptist Cemetery July 25, 1997   |  | 20c. Location - City or Town, State<br>Lyles Virginia  |  |   |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br>Robert E. Evans Funeral Home, Inc.<br>16000 Annapolis Rd. Bowie Md. 20715   |  |  |  |   |
| 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. LYMPHOMA<br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br>5 1/2 YEARS   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |   |
|  |   |   |  |   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |   |  |  |  |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how injury occurred   |
|  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |
| 29a. Certifier (Check only one)<br>2 <input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |   |  |  |  |   |
| 29b. Signature and title of certifier<br> MD  |   |   |  | 29c. License number<br>D-43346  |  | 29d. Date signed (Month, Day, Year)<br>7/22/97   |  |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>RITA GUPTA M.D. 8926 WOODYARD ROAD #201, CLINTON MD.   |   |   |  |   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1997   |   | 32. Registrar's Signature<br>  |  |   |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23822

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |  |  |
|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Bladys L Suggs</i>   |   |  |  | 2. Date of Death<br>Month <i>July</i> Day <i>21</i> Year <i>1997</i> |  | 3. Time of Death<br><i>2:45 AM</i>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Southern Maryland Hospital Clinton</i> |   |  |  | 4b. City, Town, or Location of Death<br><i>Prince George's</i>       |  | 4c. County of Death<br><i>Pitt County, NC</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>241-62-9740</i>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><i>78</i> Yrs.   | If Under 1 Year<br>Months Days                                       | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><i>09/24/1918</i>                                       | 9. Birthplace (State or Foreign Country)<br><i>Pitt County, NC</i>             |
|  | Usual Residence of Decedent   |   |  |  |  |  |  |  |
| 10a. State<br><i>MD</i>  |   | 10b. County<br><i>Prince George's</i>   |  | 10c. City, Town or Location<br><i>Capitol Heights</i>  |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><i>505 Suffolk Avenue #420</i>   |   |   |  | 10f. Zip Code<br><i>20746</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4or 5+)  |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>LP Nurse</i>   |  |  | 16b. Kind of Business/Industry<br><i>George Washington Hospital</i>                            |  |
| 17. Father's Name (First, Middle, Last)<br><i>Sam Williams</i>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Lula Blount</i>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>Nancy Suggs Shivers</i>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>7605 Georgian Drive Upper Marlboro, MD 20772</i>   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Rest Haven Cemetery</i>  |  | Date<br><i>7/26/97</i>   |  | 20c. Location - City or Town, State<br><i>Wilson, NC</i>   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Tyrone J. Young</i>  |   |   |  | 22. Name and Address of Facility<br><i>Tyrone J. Young Funeral Services<br/>5635 Eads St., NE Wash., DC 20019</i>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <i>Sepsis hypotension</i><br>Due to (or as a consequence of):<br><br>b. <i>Seizure disorder</i><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |   |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>7 days</i><br><i>7 days</i> |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><i>[Signature]</i>   |  |  |  |  |  |  |
|  |   | 29c. License number<br><i>D-24535</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>7/22/97</i>  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Laxmi N. Berwa 7700 Old Branch Ave, C101 Clinton, MD</i>  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>JUL 24 1997</i>  |   | 32. Registrar's Signature<br><i>[Signature]</i>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

(7)

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23823

## Certificate of Death

Reg. No.

|  |   |                                  |   |   |  |  |  |  |   |  |  |
|--|---|----------------------------------|---|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DANIEL SEBRING Daniel Leo Sebring</b>                    |                                  |   |   |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>19</b> Year <b>1997</b> |  | 3. Time of Death<br><b>06:48 AM</b>                         |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b> |                                  |   |   |  |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>              |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-90-4162</b>   |                                  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>19</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 27, 1978</b>           |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |  |  |
|  | Usual Residence of Decedent   |                                  |   |   |  |  |  |  |   |  |  |
| 10a. State<br><b>Maryland</b>  |   | 10b. County<br><b>St. Mary's</b> |   | 10c. City, Town or Location<br><b>Valley Lee</b>  |  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 10e. Street and Number<br><b>P.O. Box 102</b>  |   |                                  |   | 10f. Zip Code<br><b>20692</b>   |  |  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b>   |   |                                  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Carpenter</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Home Building</b>   |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Bryce Warren Sebring</b>   |   |                                  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Joan Ann Bean</b>  |  |  |   |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Bryce W. Sebring/Father</b>   |   |                                  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 102, Valley Lee, MD 20692</b> |  |  |   |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                                  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. George Cath Cem</b>  |  | Data<br><b>7/23/97</b>   |  | 20c. Location - City or Town, State<br><b>Valley Lee, MD</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael J. Gardiner</i>  |   |                                  |   |   |  | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>            |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CHEST AND ABDOMINAL INJURIES</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |                                  |   |   |  |  |  |  |   | Approximate interval Between Onset and Death |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |                                  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |
|  |   |                                  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|  |   |                                  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |                                  |   | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |                                  |   | 28e. Date of Injury (Month, Day, Year)<br><b>7-19-97</b>  |  | 28b. Time of Injury<br><b>00:37 AM</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|  |   |                                  |   | 28d. Describe how Injury occurred<br><b>DRIVER OF AUTO WHICH RUN OFF ROADWAY AND ROLLED OVER</b>  |  |  |  |  |   |  |  |
|  |   |                                  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>MD<br/>RITCHIE ROAD, VALLEY LEE</b>  |  |  |  |  |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                                  |   | 29b. Signature and title of certifier<br><i>Mario F. Grolle Jr.</i> DME   |  | 29c. License number<br><b>D33954</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 1997</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARIO F. GROULE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>   |   |                                  |   |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |   |                                  |   | 32. Registrar's Signature<br><i>John Davidson R-1-11</i>  |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23824

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Alexander Stuart</b>   |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>11</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:30 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Holy Cross Hospital</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Silver Spring</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>087-03-5392</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 22, 1916</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Wheaton</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>4011 Randolph Road</b>   |  | 10f. Zip Code<br><b>20902</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 years</b> Collage (1-4or 5+) <b>3 1/2 years</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Restaurant owner</b>  |  | 16b. Kind of Business/Industry<br><b>Restaurant owner</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Bernard Stavracos</b>   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frances Dukas Stavracos</b>   |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia West</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>140 West End Ave. New York, New York 10023</b>   |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Rock Creek Cemetery</b>  |  | 20c. Date<br><b>7/25/97</b>   |  | 20d. Location - City or Town, State<br><b>Washington, D.C.</b>   |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br><b>Joseph Gawlers, sons<br/>5130 Wisconsin Ave. Washington D.C. 20016</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Respiratory Failure</b><br>Due to (or as a consequence of):<br><b>b. Pneumonia</b><br>Due to (or as a consequence of):<br><b>c. Post Anoxic Encephalopathy</b><br>Due to (or as a consequence of):<br><b>d.</b> |  | Approximate Interval Between Onset and Death<br><b>Minutes</b><br><b>Weeks</b><br><b>Months</b>  |  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)<br><b>7/25/97</b>  |  | 28b. Time of Injury<br><b>M</b>   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>D-32332</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7-12-97</b>   |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Suresh Kumar Gupta 9801 Georgia Ave, #220 Silver Spring, M.d. 20902</b>  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>   |  | 32. Registrar's Signature<br>   |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23825

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

|   |  |   |  |  |  |  |  |  |  |   |  |
|---|--|---|--|--|--|--|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Lydia Striha</b>   |  | 2. Date of Death<br>Month <b>July</b> Day <b>23</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:45 PM</b>   |  |  |  |  |  |   |  |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Mariner Health of Bethesda</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>  |  | 4c. County of Death<br><b>Montgomery</b> |  |  |  |  |   |  |
| 5. Social Security Number<br><b>579-42-3043</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>December 18, 1904</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Russia</b>  |  |   |  |
| Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |   |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Bethesda</b>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |
| 10e. Street and Number<br><b>5721 Grosvenor Lane</b>  |  |   | 10f. Zip Code<br><b>20814</b>  |  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+) <b>2</b>  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>machine operator</b> |  |  | 16b. Kind of Business/Industry<br><b>factory</b>   |  |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>(unavailable) Perchod</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>unavailable</b>  |  |  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Adolf G. Wassiliew</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10521 Seneca Ridge Drive, Gaithersburg, MD 20879</b>                                     |  |  |  |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory</b>   |  | Data<br><b>7-24-97</b>   |  | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>   |  |  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Rapp Funeral Services, P.A.<br/>933 Gist Avenue, Silver Spring, Maryland 20910</b>  |  |  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebrovascular Accident</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. {</b><br><b>c. {</b><br><b>d. {</b> |  |   |  |  |  | Approximate Interval Between Onset and Death<br>Hours  |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypothyroidism</b><br><b>Dementia</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |   |  |
|   |  |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |   |  |
|   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D23911</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 24, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David A. Blass, M.D. 9410 Old Georgetown Road, Bethesda, Maryland 20814</b>  |  |   |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>   |  | 32. Registrar's Signature<br>  |  |  |  |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

2

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

97 23826

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HARRY NATHAN STEIN

2. Date of Death

Month Day Year  
JULY 14, 1997

3. Time of Death

2:05PM

4a. Facility Name (If not institution, give street and number)

SUBURBAN HOSPITAL

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

057-10-2952

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
AUG. 12, 1908

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

BETHESDA

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6530 DEMOCRACY BLVD.

10f. Zip Code

20817

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - if Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LAWYER

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

ISADORE STEIN

18. Mother's Name (First, Middle, Maiden Surname)

SARA "UNKNOWN"

19a. Informant's Name/Relationship (Type, Print)

JOHN STEIN/SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 REGEN ROAD, DANBURY, CT 06811

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KING DAVID MEMORIAL GARDENS 7/16/97 FALLS CHURCH, VIRGINIA

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC.

1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. SEPSIS Gram Negative  
Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 days

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIO SCLEROSIS

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29e. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D31319

29d. Date signed (Month, Day, Year)

7-15-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

DR. LORETA ALBIOL, 2 WISCONSIN AVENUE, CHEVY CHASE, MARYLAND 20815

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

20



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23827

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

VIRGINIA NICKLIN SPRUILL

2. Date of Death

Month Day Year  
JULY 22 1997

3. Time of Death

1320 PM

4a. Facility Name (If not institution, give street and number)

Suburban Hospital

4b. City, Town, or Location of Death

Bethesda

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

220-10-7735

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

78

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 10, 1919

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

North Potomac

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

11531 Pleasant Meadows Drive

10f. Zip Code

20878

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Executive Director

16b. Kind of Business/Industry

Motion Picture

17. Father's Name (First, Middle, Last)

Harry Nicklin

18. Mother's Name (First, Middle, Maiden Surname)

Edith Willison

19a. Informant's Name/Relationship (Type, Print)

Dudley Spruill / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11531 Pleasant Meadows Drive, N. Potomac, MD 20878

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Montgomery Crematorium, Inc. July 24, 1997

20c. Location - City or Town, State

Bethesda, Maryland

21. Signature of Funeral Service Licensee

Theresa P. Kutto M00348

22. Name and Address of Facility Robert A. Pumphrey Funeral Home/  
Rockville, Inc., 300 W. Montgomery Avenue,  
Rockville, Maryland 20850-280523a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. PNEUMONIA

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

ACUTE

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. MULTIPLE TRAUMA

Due to (or as a consequence of):

4 WKS

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PARKINSONISM

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☒ Accident 6 ☐ Could not be  
3 ☐ Suicide 4 ☐ Homicide determined28a. Date of Injury  
(Month, Day, Year)

JUNE 26 1997

28b. Time of  
Injury

P M

28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FELL DOWN STEPS

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Theresa P. Kutto

29c. License number

D07099

29d. Date signed (Month, Day, Year)

JULY 22 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANK C MAYHE 2215 KERNWOOD RD BETHESDA MD 20817

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,




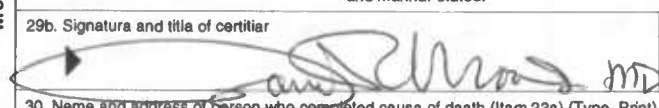
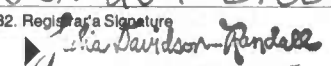
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23828

## Certificate of Death

Reg. No.

|  |  |   |  |  |                                |  |   |  |   |  |
|--|--|---|--|--|--------------------------------|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Barbara Weaver Spearman</b>                         |   |  |  |                                |  | 2. Date of Death<br>Month <b>July</b> Day <b>22</b> Year <b>1997</b>    |  | 3. Time of Death<br><b>8:10 AM</b>                      |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>WILSON HEALTH CARE CENTER</b> |   |  |  |                                |  | 4b. City, Town, or Location of Death<br><b>GAITHERSBURG</b>             |  | 4c. County of Death<br><b>MONTGOMERY</b>                |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>578-20-4234</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs.   | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>DEC. 18, 1906</b>             |  | 9. Birthplace (State or Foreign Country)<br><b>R.I.</b> |  |
|  | Usual Residence of Decedent  |   |  |  |                                |  |   |  |   |  |
| 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>GAITHERSBURG</b>   |                                |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
| 10e. Street and Number<br><b>301 RUSSELL AVE. #431</b>   |  |   |  | 10f. Zip Code<br><b>20877</b>  |                                | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br><b>4</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>RET. - WORKER</b>  |                                |  | 16b. Kind of Business/Industry<br><b>PHYSICAL THERAPY</b>               |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>HAROLD EARL WEAVER</b>   |  |   |  |  |                                | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA ELECTA STOTT</b>  |   |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>FRANCES W. LATHROP-DREW/SISTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>41 MEADOWBROOK DR., BARRINGTON, R.I. 02806</b>   |                                |  |   |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>  |                                | Data<br><b>7/24/97</b>   |   | 20c. Location - City or Town, State<br><b>RIVERDALE, MD.</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>MOO091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>   |                                |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Cerebral Thrombosis</b><br>Due to (or as a consequence of):<br><br>b. <b>Cerebral arteriosclerosis</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of): |  |   |  |  |                                |  |   |  |   |  |
| Approximate Interval Between Onset and Death<br><b>1 hour</b><br><b>6 years</b>  |  |   |  |  |                                |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Normal pressure hydrocephalus</b>   |  |   |  |  |                                | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |  |
|  |  |   |  |  |                                | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |                                |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicidal <input type="checkbox"/> Homicidal<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how Injury occurred  |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |                                |  |   |  |   |  |
| 29b. Signature and title of certifier<br> MD  |  |   |  | 29c. License number<br><b>07231</b>  |                                | 29d. Date signed (Month, Day, Year)<br><b>July 22, 1997</b>  |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James R. Moore Jr. 207 Brooke Ave Gaithersburg MD 20877</b>   |  |   |  |  |                                |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |                                |  |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

1. The first part of the paper is devoted to a discussion of the

main results of the paper.

2. The second part of the paper is devoted to a discussion of the

main results of the paper.

3.

4.

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13.

14. The third part of the paper is devoted to a discussion of the

main results of the paper.

15. The fourth part of the paper is devoted to a discussion of the

main results of the paper.

16.

17. The fifth part of the paper is devoted to a discussion of the

main results of the paper.

18. The sixth part of the paper is devoted to a discussion of the

19.

20.

21.

22.

23.

24.

25.

26.

27.

28.

29.

30.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23829

## Certificate of Death

Reg. No.

|   |  |  |   |   |  |                                 |  |  |  |   |  |   |  |   |  |
|---|--|--|---|---|--|---------------------------------|--|--|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>BRUCE H. SNELL</b>  |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>20</b> Year <b>1997</b>  |  |                                 | 3. Time of Death<br><b>8:20 PM</b>                           |  |  |   |  |   |  |   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>5043 Beatrice Way</b>   |  |   | 4b. City, Town, or Location of Death<br><b>Columbia</b>   |  |                                 | 4c. County of Death<br><b>HOWARD</b>                         |  |  |   |  |   |  |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-36-5329</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |                                 | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 25, 1938</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                                    |   |  |   |  |   |  |
|   | Usual Residence of Decedent  |  |   |   |  |                                 |  |  |  |   |  |   |  |   |  |
| To Be Completed by Funeral Director   | 10e. State<br><b>MD</b>  |  | 10b. County<br><b>Howard</b>  |   | 10c. City, Town or Location<br><b>Columbia</b>   |                                 |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |   |  |   |  |
|   | 10e. Street and Number<br><b>5043 Beatrice Way</b>   |  |   |   | 10f. Zip Code<br><b>21044</b>  |                                 | 10g. Citizen of What Country?<br><b>U.S.A.</b>               |  |  |   |  |   |  |   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                 |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>          |  |   |  |   |  |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>12th</b>   |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Self Employed</b>  |                                 |  |  | 16b. Kind of Business/Industry<br><b>Automotive Co.</b>  |   |  |   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James D. Snell</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dorothy Watkins</b>  |                                 |  |  |  |   |  |   |  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth A. Snell (Wife)</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5043 Beatrice Way, Columbia, MD 21044</b>  |                                 |  |  |  |   |  |   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Crestlawn Cemetery</b>  |                                 | Date<br><b>7/24/97</b>                                       |  | 20c. Location - City or Town, State<br><b>Marriottsville, MD</b>                               |   |  |   |  |   |  |
|   | 21. Signature of Funeral Service Licensee<br><i>George R. Snowden</i>  |  |   |   | 22. Name and Address of Facility<br><b>SNOWDEN FUNERAL HOME, P.A.<br/>ROCKVILLE, MD 20850</b>  |                                 |  |  |  |   |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. METASTATIC PANCREATIC CANCER</b><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |                                 |  |  |  |   | Approximate Interval Between Onset and Death<br><b>9 MONTHS</b>  |   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |                                 |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   |   |  |                                 |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                                 |  |  |  |   |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  |  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b> |  | 28c. Injury et Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred   |  |   |  |   |  |
|   |  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                 |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |   |   |  |                                 |  |  |  | 29b. Signature and title of certifier<br><i>Michael W. [Signature]</i>  |  | 29c. License number<br><b>D33224</b>                          |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 22, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Ram Trehan, MD 50 Edmonston Drive, Rockville, MD 20852</b>   |  |  |   |   |  |                                 |  |  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>   |  | 32. Registrar's Signature<br><i>John Davidson [Signature]</i> |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23830

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |  |  |   |  |
|--|---|--|---|--|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>DEBROAH DEBRA ANN SMALL   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 17, 1997  |  | 3. Time of Death<br>1720   |  |  |  |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL  |  |   |  | 4b. City, Town, or Location of Death<br>ROCKVILLE  |  | 4c. County of Death<br>MONTGOMERY  |  |  |  |   |  |
| Funeral<br>Director  | 5. Social Security Number<br>218-66-6678  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>41 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>April 6, 1956                                 |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |   |  |
|  | Usual Residence of Decedent   |  |   |  |  |  |  |  |  |  |   |  |
| To Be Completed by Funeral Director                                  | 10e. State<br>MD  |  | 10b. County<br>Montgomery   |  | 10c. City, Town or Location<br>Gaithersburg  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |   |  |
|  | 10e. Street and Number<br>126 Duvall Lane, #102   |  |   |  | 10f. Zip Code<br>20877   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |  |  |   |  |
|  | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>if Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black |  |  |   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (14 or 5+) College   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>N/A (Disabled)   |  |  | 16b. Kind of Business/Industry<br>None |  |  |  |  |   |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br>Nathaniel H. Small, Sr.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Mary E. Jordan  |  |  |  |  |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Dolores R. Robinson (Friend)  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>126 Duvall Lane, #102, Gaithersburg, MD 20877   |  |  |  |  |  |   |  |
|  | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Gate of Heaven Cem.   |  | Date<br>7/25/97  |  | 20c. Location - City or Town, State<br>Silver Spring, MD                             |  |  |  |   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>George R. Snowden</i>   |  |   |  | 22. Name and Address of Facility<br>SNOWDEN FUNERAL HOME, P.A.<br>ROCKVILLE, MD 20850  |  |  |  |  |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>e. <i>colon cancer</i><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |  |  |  |  |  |  | Approximate Interval Between Onset and Death<br><i>one year</i> |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |  |  |  |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |   |  |  |  |  |  |  |  |   |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  |  |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |   |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |   |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                       |  |   |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |  |  |   |  |
| State Registrar  | 29b. Signature and title of certifier<br><i>Albert Steren</i>   |  |   |  | 29c. License number<br>D38682  |  |  |  | 29d. Date signed (Month, Day, Year)<br>July 17 1997  |  |   |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Albert Steren 10415 Fernwood Dr #405 Bethesda md 20817  |  |   |  |  |  |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br>JUL 24 1997                     |   | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i> |   |  |  |  |  |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23831

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ALBERT HA SINCLAIR

2. Date of Death

Month Day Year  
July 14 1997

3. Time of Death

4:47 AM

4a. Facility Name (If not institution, give street and number)

Washington Adventist Hospital

4b. City, Town, or Location of Death

Takoma Park

4c. County of Death

Montgomery

Funeral  
Director

5. Social Security Number

579-72-7348

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

56

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 3, 1941

9. Birthplace (State or Foreign Country)

Jamaica

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

9268 Piney Branch Road

10f. Zip Code

20905

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8th

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Nurses' Aide

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Hubert Sinclair

18. Mother's Name (First, Middle, Maiden Surname)

Deresa Baily

19a. Informant's Name/Relationship (Type, Print)

Marvia Housen

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1349 Riggs Street, N.W., Washington, DC 20009

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gate of Heaven Cemetery

Date

7/26/97

20c. Location - City or Town, State

Silver Spring, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

R. N. Horton Co. Morticians, Inc.

600 Kennedy Street, N.W., DC, 20011

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

b. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

END STAGE RENAL DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury et  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

MD

29c. License number

D41662

29d. Date signed (Month, Day, Year)

JULY 15, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JARED KRONLI

7600 Carroll Ave. Takoma, PK MD 20912

CH WASHINGTON ADVENTIST HOSPITAL

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



# MISSING

DEATH

certificate no.: 97-23832

DEATH

DL-93839



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23833

## Certificate of Death

Reg. No.

|  |  |   |  |  |  |  |  |   |
|--|--|---|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Beatrice R. Sikow</b>                                 |   |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>13</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:20PM</b>       |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Montgomery General Hospital</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Olney</b>                 |  | 4c. County of Death<br><b>Montgomery</b> |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>113-12-1721</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                                       | 8. Date of Birth (Month, Day, Year)<br><b>JAN. 21, 1919</b>                                    |  | 9. Birthplace (State or Foreign Country)<br><b>NY</b> |
|  | Usual Residence of Decedent  |   |  |  |  |  |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>SILVER SPRING</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |   |
| 10e. Street and Number<br><b>14400 HOMECREST RD., #110</b>   |  |   |  | 10f. Zip Code<br><b>20906</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>HOUSEWIFE</b>  |  | 16b. Kind of Business/Industry<br><b>OWNHOME</b>   |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>MORRIS VAN VORT</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>SARAH FRANKENSTEIN</b>   |  |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>DIANE CHADDOCK / DAUGHTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19905 APPLIEDOWRE CIRCLE, GERMANTOWN, MD 20876</b>                                       |  |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. LEBANON CEMETERY</b>   |  | Date<br><b>7/16/97</b>   |  | 20c. Location - City or Town, State<br><b>QUEENS, NY</b>                                       |  |   |
| 21. Signature of Funeral Service Licensee<br><br><b>DANIEL SIMONS</b>  |  |   |  | 22. Name and Address of Facility<br><b>EDWARD SAGEL FUNERAL DIRECTION, INC.<br/>1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>   |  |  |  |   |
| 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>PNEUMONIA</b><br>Due to (or as a consequence of):<br>b. <b>STEROID DEPENDENT OBSTRUCTIVE LUNG DISEASE</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br><b>48 HR.</b><br><b>40 YR.</b> |  |   |  |  |  |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>NONE</b>  |  |   |  |  |  |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |   |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28d. Describe how injury occurred  |  |  |  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |  |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |   |
| 29b. Signature and title of certifier<br><br><b>Frank J. Mayo, MD - Attending</b>   |  |   |  | 29c. License number<br><b>023630</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 14, 1997</b>                                    |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Frank J. Mayo, MD 16220 Frederick RD #213, Gaithersburg, MD 20877</b>   |  |   |  |  |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |  |   |  | 32. Registrar's Signature<br>   |  |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



97 23834

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |  |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Corinne W. Schreiber   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 16, 1997  |  | 3. TIME OF DEATH<br>5:20 A M   |  |
| 4. SOCIAL SECURITY NUMBER<br>138-05-4708   |  | 5. SEX<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>90 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>June 20, 1907   |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>New York   |  |  |  | 9a. FACILITY NAME (If not institution, give street and number)<br>Hebrew Home of Greater Washington  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Rockville   |  |
| 9c. COUNTY OF DEATH<br>Montgomery  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Montgomery  |  |
| 10c. CITY, TOWN OR LOCATION<br>Rockville   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>6121 Montrose Rd.  |  |
| 10f. ZIP CODE<br>20852   |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States   |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Homemaker  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Own Home   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>William Weinberg  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Rebecca Jacobson  |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>David Schreiber  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5227 Conneticut Ave. N.W., Washington, DC 20015   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Beth El Cemetery 7-18-97  |  | 20c. LOCATION — City or Town, State<br>Emerson, New Jersey   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Frank Asfame</i>   |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>Danzansky-Goldberg Mem. Chapels, Inc.<br>1170 Rockville Pike, Rockville, MD  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |  |  |  |  |  |  |
| IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia, Both Lower Lobes</i>  |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| b. <i>Presumably viral</i>   |  |  |  |  |  |  |  |
| DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| c.<br>DUE TO (OR AS A CONSEQUENCE OF):   |  |  |  |  |  |  |  |
| d.<br>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST   |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |  |  |  |  |
| 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  |  |  |  |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |  |  |  |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M   |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Dr. [Signature]</i> Attending Physician  |  |  |  | 29c. LICENSE NUMBER<br>D18084  |  | 29d. DATE SIGNED (Month, Day, Year)<br>JULY 16, 1997   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>D.D. PATEL M.D. 6121 MONTROSE RD, ROCKVILLE, MD 20852   |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 22 1997   |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>Jana Davidson-Randall</i>  |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23835

## Certificate of Death

Reg. No.

|   |   |  |                                 |   |  |   |  |  |
|---|---|--|---------------------------------|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Gunther Fritz Carl Schmidt</b>             |  |                                 |   | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1997</b> |   | 3. Time of Death<br><b>1:30 pm</b>                           |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>4311 Locust Lane</b> |  |                                 |   | 4b. City, Town, or Location of Death<br><b>Bethesda</b>              |   | 4c. County of Death<br><b>Montgomery</b>                     |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-54-6420</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F |   | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.                     |   | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 29, 1920</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>                                |  | 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Montgomery</b>                                     |   | 10c. City, Town or Location<br><b>Bethesda</b>               |  |
| Usual Residence of Decedent   |   | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |                                 | 10e. Street and Number<br><b>4311 Locust Lane</b>   |  | 10f. Zip Code<br><b>20816</b>   |  |  |
| 10g. Citizen of What Country?<br><b>United States</b>   |   | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced  |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No, if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify: |  |  |
| 14. Race - American Indian, Black, White, etc.<br><b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-</b>  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Pastry Chef</b>                           |  | 16b. Kind of Business/Industry<br><b>Airline</b>  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Fritz W. Schmidt</b>  |   |  |                                 | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helene S. Not Available</b>   |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rudolf K. Cebulla/ Executor</b>  |   |  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10013 Menlo Avenue, Silver Spring, Maryland 20910</b> |  |   |  |  |
| 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>  |                                 | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>  |  | 20d. Date<br><b>July 22, 1997</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><br><b>M00689</b>  |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, Maryland 20814-3501</b>                        |                                 |   |  |   |  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Acute Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b><br>Due to (or as a consequence of): |   | Approximate Interval Between Onset and Death<br><b>10 Min.</b>   |                                 |   |  |   |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |   | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |                                 | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No   |  |   |  |  |
| 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |   | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify) |                                 |   |  |   |  |  |
| 27. Manner of Death<br><b>1</b> Natural <b>5</b> Pending investigation<br><b>2</b> Accident <b>6</b> Could not be determined<br><b>3</b> Suicide <b>4</b> Homicide  |   | 28a. Date of Injury (Month, Day, Year)   |                                 | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  |  |
| 28d. Describe how Injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |                                 | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
| 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br>   |                                 | 29c. License number<br><b>D 08546</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 20, 1997</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>John F. Tauber M.D. 8218 Wisconsin Avenue # 318 Bethesda, Maryland 20814</b>   |   | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |                                 |   |  |   |  |  |
| 32. Registrar's Signature<br>  |   |  |                                 |   |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23836

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JUDITH SCHAFFER

2. Date of Death

Month Day Year  
JULY 13 1997

3. Time of Death

8:00PM

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

5. Social Security Number

219 29 8874

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

91 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JANUARY 15, 1906

9. Birthplace (State or Foreign Country)

POLAND

Usual Residence of Decedent

10e. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE ROAD

10f. Zip Code

20852

10g. Citizen of What Country?

ISRAEL

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

YECHESKIEL STERNSHUSS

18. Mother's Name (First, Middle, Maiden Surname)

RACHEL (UNKNOWN)

19a. Informant's Name/Relationship (Type, Print)

YECHESKIEL SCHAFFER/ SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

109 MONUMENT STREET, ROCKVILLE, MD 20850

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☒ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

KIRIAT SHAUL

Date

7/15/97

20c. Location - City or Town, State

TEL AVIV ISRAEL

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC  
1170 ROCKVILLE PIKE, ROCKVILLE MD 20852

23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. CORONARY ARTERY DISEASE

Due to (or as a consequence of):

YEARS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. GENERALIZED ARTEROSCLEROSIS

Due to (or as a consequence of):

YEARS

c. HYPERTENSION

Due to (or as a consequence of):

YEARS

d.

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBROVASCULAR DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D 05885

29d. Date signed (Month, Day, Year)

JULY 14, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEVEN LIPSON 6121 MONTROSE ROAD, ROCKVILLE, MD

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23837

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Charles Sacks</b>   |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>13</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1:15 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Manor Care-Fernwood</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Bethesda</b>   |  | 4c. County of Death<br><b>Montgomery</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>010-03-9967</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 25, 1910</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Massachusetts</b>   |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Montgomery</b>  |  | 10c. City, Town or Location<br><b>Rockville</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>1801 East Jefferson St.</b>  |  | 10f. Zip Code<br><b>20852</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)                       |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Owner</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Fuel Oil Business</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Albert Sacks</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie Schabel</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Frieda Sacks (Wife)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1801 East Jefferson St., Rockville, MD. 20852</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mohliver Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>7-16-97 Boston, Massachusetts</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |  |  | 22. Name and Address of Facility<br><b>Danzansky-Goldberg Mem. Chapels, Inc<br/>1170 Rockville Pike, Rockville, MD. 20852</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>CEREBROVASCULAR ACCIDENT</b><br>Due to (or as a consequence of):<br><b>ARTERIOSCLEROSIS</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>ALZHEIMER'S DISEASE</b><br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death<br><b>24 HRS</b><br><b>OLD</b>   |  |   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ALZHEIMER'S DISEASE</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. Signature and title of certifier<br>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br><b>D 31319</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 14 1997</b>  |  |   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>LORETO ALBIOL, MD, 2 WISCONSIN CIRCLE, CHEVY CHASE, MD 20815</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>JUL 21 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 32. Registrar's Signature<br>  |  |  |  | 33. Registrar's Title<br><b>Julia Davidson-Rendell</b>  |  |   |  |
|   | 34. Registrar's Name<br><b>Julia Davidson-Rendell</b>  |  |  |  | 35. Registrar's Address<br><b>20815</b>   |  |   |  |



97 23838

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>Frederick Wilhelm Senkel, Jr.   |  |  |  | 2. DATE OF DEATH<br>MONTH DAY YEAR<br>July 19, 1997  |  | 3. TIME OF DEATH<br>12:11 P.M.   |  |
| 4. SOCIAL SECURITY NUMBER<br>220-20-5411  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 6. AGE (In yrs. last birthday)<br>68 YRS.  |  | 7. DATE OF BIRTH (Month, Day, Year)<br>Dec. 1, 1928  |  |
| 8. BIRTHPLACE (State or Foreign Country)<br>Maryland  |  |  |  | 9a. FACILITY NAME (If not Institution, give street and number)<br>Frederick Memorial Hospital  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Frederick   |  |
| 9c. COUNTY OF DEATH<br>Frederick  |  |  |  | 10a. STATE<br>Maryland   |  | 10b. COUNTY<br>Frederick   |  |
| 10c. CITY, TOWN OR LOCATION<br>Thurmont   |  |  |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 10e. STREET AND NUMBER<br>13707 Strafford Drive  |  |
| 10f. ZIP CODE<br>21788  |  |  |  | 10g. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  |
| 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES<br>WWII  |  |  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:  |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White   |  |
| 15. DECEDENT'S EDUCATION (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5 +)  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)<br>Colonel/Policeman  |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Police Department  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Frederick Wilhelm Senkel   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>Gertrude Hutchinson   |  |  |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Mr. Frederick W. Senkel, III  |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>13707 Strafford Drive, Thurmont, MD 21788   |  |  |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Lake View Memorial Park 7/23  |  | 20c. LOCATION — City or Town, State<br>Sykesville, MD  |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Brian L. Hayles  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br>HAIGHT FUNERAL HOME & CHAPEL (Box 195)<br>Sykesville, MD 21784 (410)-795-1400  |  |  |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD<br>DUE TO (OR AS A CONSEQUENCE OF):<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST<br>b. DUE TO (OR AS A CONSEQUENCE OF):<br>c. DUE TO (OR AS A CONSEQUENCE OF):<br>d. |  |  |  |  |  |  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |  |  |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br>M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |
| 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  | 28d. DESCRIBE HOW INJURY OCCURRED  |  | 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |  | 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Dr. Andrew Zarick  |  |  |  | 29c. LICENSE NUMBER<br>D35164  |  | 29d. DATE SIGNED (Month, Day, Year)<br>7-21-97   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br>Dr. Andrew Zarick 130 Thomas Johnson Dr., Frederick, MD 21702  |  |  |  |  |  |  |  |
| 31. DATE FILED (Month, Day, Year)<br>JUL 23 1997  |  |  |  | 32. REGISTRAR'S SIGNATURE<br>Julia Shuckor-Randall   |  |  |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23839

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

To Be Completed by Funeral Director

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Joseph Robert Stewart</b>  |  |  |  | 2. Date of Death<br>Month <b>July</b> Day <b>21</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>2:30 p.m.</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>16512 Brandywine Rd</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>Brandywine</b>   |  | 4c. County of Death<br><b>Prince Georges</b>  |  |
| 5. Social Security Number<br><b>217-42-2664</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>52</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>October 2, 1944</b>                               |  |
| 9. Birthplace (State or Foreign Country)<br><b>Washington D.C.</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince Georges</b>  |  | 10c. City, Town or Location<br><b>Brandywine</b>  |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>16512 Brandywine Rd</b>   |  | 10f. Zip Code<br><b>20613</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Mail Handler</b>   |  | 16b. Kind of Business/Industry<br><b>United State Government</b>  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Robert H. Stewart</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Stewart</b>  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert H. Stewart</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>16512 Brandywine Rd, Brandywine MD 20613</b>  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Resurrection Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Clinton MD</b>  |  | 20d. Date<br><b>July 25/97</b>  |  |
| 21. Signature of Funeral Service Licensee<br>   |  | 22. Name and Address of Facility<br><b>Adams Funeral Home, Agawam MD 20608</b>   |  |   |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>HLV infection</b><br/>Due to (or as a consequence of):</p> <p>b. <b>HLV</b><br/>Due to (or as a consequence of):</p> <p>c. <b>Candida Esophagitis</b><br/>Due to (or as a consequence of):</p> <p>d. <b>bowel obstruction</b></p> </div> <div style="width: 35%;"> <p>Approximate Interval Between Onset and Death<br/><b>24 hr</b></p> </div> </div> |  |  |  |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how injury occurred  |  |   |  |   |  |
| 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |
| 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>024208</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7-22-97</b>   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>ABUL HASAN U ANSARI 8926 Woodyard Rd #101 Clinton MD 20735</b>   |  |  |  |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 28 1997</b>   |  | 32. Registrar's Signature<br>  |  |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar

902-20

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23840

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Mary Elizabeth Swales

2. Date of Death

Month Day Year  
July 10, 1997

3. Time of Death

7:15 p.m.

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

220-64-7425

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 11, 1922

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Lexington Park

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

19745 Three Notch Road

10f. Zip Code

20653

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Black

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
11

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Housekeeper

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

George Henry Swales

18. Mother's Name (First, Middle, Maiden Surname)

Emma Young

19a. Informant's Name/Relationship (Type, Print)

Theresa A. King, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2641 Shadyside Avenue, Apartment 103, Suitland, Maryland 20746

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Our Lady's Church Cemetery

Date

7-15-1997

20c. Location - City or Town, State

Leonardtown, Maryland

21. Signature of Funeral Service Licensee

Michael K. Blankenship, #00852

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, Maryland 20650-0279Physician  
/Medical  
Examiner23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Respiratory Failure  
Due to (or as a consequence of):b. Carcinomatosis  
Due to (or as a consequence of):c. Carcinoma of Breast  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

hrs.

min.

lys.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure  
Diabetes Mellitus  
Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D 06419

29d. Date signed (Month, Day, Year)

7-11-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Patrick Jarboe, M.D., 22650 Peabody Street, P.O. Box 306, Leonardtown, Maryland 20650-0306

31. Date filed (Month, Day, Year)

JUL 15 1997

32. Registrar's Signature

J. Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
important: If item 27 is marked other than "natural", or items 23a or 28e-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23841

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |  |  |
|---|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Jonas Sensenig Stauffer   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 13, 1997   |  | 3. Time of Death<br>4:40 PM                                      |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Greenwell State Park  |  |   |  | 4b. City, Town, or Location of Death<br>Hollywood   |  | 4c. County of Death<br>St. Mary's                                |  |
| Funeral<br>Director                           | 5. Social Security Number<br>N/A  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>17 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>Dec 27, 1979              |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10a. State<br>Maryland  |  | 10b. County<br>St. Mary's   |  | 10c. City, Town or Location<br>Loveville                         |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>P.O. Box 115  |  | 10f. Zip Code<br>20656  |  | 10g. Citizen of What Country?<br>U.S.A.                          |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th Grade   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Farmer                                   |  | 16b. Kind of Business/Industry<br>Farm  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Henry Brubacher Stauffer   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alma Martin Sensenig   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br>Henry B. Stauffer/Father  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>P.O. Box 115, Loveville, MD 20656  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Loveville Mennonite Cem.  |  | Date<br>7/17/97   |  | 20c. Location - City or Town, State<br>Loveville                 |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Michael J. Gardiner  |  |   |  | 22. Name and Address of Facility<br>Mattingley-Gardiner Funeral Home, P.A.<br>P.O. Box 270, Leonardtown, Maryland 20650   |  |  |  |
|   | 23a. Part I: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. Drowning<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br><br>24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br><br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br><br>25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br><br>26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) STATE PRISON<br><br>27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined<br><br>28a. Date of Injury (Month, Day, Year)<br>7-13-97<br>28b. Time of Injury<br>1050 M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>28d. Describe how injury occurred<br>Drowning<br>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)<br>PATUXENT RIVER<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Hollywood, MD<br><br>29a. Certifier<br>(Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><br>29b. Signature and title of certifier<br>William D. Boyd, II, M.D.<br>29c. License number<br>014285<br>29d. Date signed (Month, Day, Year)<br>7-14-97<br><br>30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>William D. Boyd, II, M.D. Leonardtown, MD 20650<br><br>31. Data filed (Month, Day, Year)<br>JUL 15 1997<br>32. Registrar's Signature<br>John Davidson Randall |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 23842

JOHN WILLIAM STATON

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>JOHN WILLIAM STATON</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 20, 1997</b>   |  | 3. Time of Death<br><b>7:05 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>5002 ROLLER ROAD</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>MILLERS</b>   |  | 4c. County of Death<br><b>CARROLL</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-34-0082</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>60</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR 30, 1937</b>                                  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>KENTUCKY</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CARROLL</b>  |  | 10c. City, Town or Location<br><b>MILLERS</b>   |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>5002 ROLLER ROAD</b>   |  | 10f. Zip Code<br><b>21102</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                     |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SELF EMPLOYED</b>   |  | 16b. Kind of Business/Industry<br><b>TRUCKING</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH NORMAN STATON</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>EVELYN MARTHA DANIELS</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>NANCY STATON, WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5002 ROLLER RD, MILLERS, MD 21102</b>  |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM GARD</b>  |  | Date<br><b>7/23</b>  |  | 20c. Location - City or Town, State<br><b>TIMONIUM, MD</b>                                  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>ELINE FUNERAL HOME<br/>934 SOUTH MAIN ST, HAMPSTEAD, MD 21074</b>  |  |  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hanging</b><br>Due to (or as a consequence of):<br><br><b>b.</b><br>Due to (or as a consequence of):<br><br><b>c.</b><br>Due to (or as a consequence of):<br><br><b>d.</b> |  |   |  |  |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |
|   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |  |  |   |  |
| To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once. | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)<br><b>Found 7-20-97</b>   |  | 28b. Time of Injury<br><b>unknown</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred<br><b>hanged with rope in garage</b>   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>   |  |  |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>5002 Roller Road Carroll County, Maryland</b>   |  |   |  |  |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 1997</b>                                 |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |  |   |  |
|   | 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |  | 32. Registrar's Signature<br>   |  |  |  |   |  |
|   | State Registrar  |  |   |  |  |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23843

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Lawrence Daryl Smith

2. Date of Death

Month Day Year  
July 19 1997

3. Time of Death

2:30 pm

4a. Facility Name (If not institution, give street and number)

9330 Gorman Road Lot 4

4b. City, Town, or Location of Death

Laurel

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

213-54-7892

6. Sex

1 ☒ M 2 ☐ F

7. Age (in yrs. last birthday)

45 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Oct 8, 1951

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

Howard

10c. City, Town or Location

Laurel

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

9330 Gorman Road Lot 4

10f. Zip Code

20723

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1970-7113. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
Grade 8

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Truck Driver

16b. Kind of Business/Industry

Recycling Company

17. Father's Name (First, Middle, Last)

David Smith, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Cecil Margaret Newton

19a. Informant's Name/Relationship (Type, Print)

Karen Smith

spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9330 Gorman Road Lot 4, Laurel, Maryland 20723

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Ivy Hill Cemetery

Date

7/22/97

20c. Location - City or Town, State

Laurel, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Donaldson Funeral Home, P.A.

313 Talbott Ave. Laurel, Maryland 20707-4389

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Cardiac Dysrhythmia

Approximate  
Interval Between  
Onset and Death

minutes

Due to (or as a consequence of):

b. Coronary Artery Disease

10 years

Due to (or as a consequence of):

c. Hypertension

10 years

Due to (or as a consequence of):

d.

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic obstructive pulmonary disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D50500

29d. Date signed (Month, Day, Year)

July 21, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

3459 ST. JOHNS LANE STE 1 ELLICOTT CITY, MD 21042

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23844

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DOROTHY L. THOMPSON

2. Date of Death

Month Day Year  
JULY 19, 1997

3. Time of Death

0435 am

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

215-38-3193

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

72 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
JAN 14, 1925

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10e. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

GERMANTOWN

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

18513 NUTMEG PLACE

10f. Zip Code

20874

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: BLACK

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

7

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

HOUSEKEEPING

17. Father's Name (First, Middle, Last)

CORNELIUS THOMPSON

18. Mother's Name (First, Middle, Maiden Surname)

MINNIE PEARL AGEE

19e. Informant's Name/Relationship (Type, Print)

PEARL WILSON, DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

18513 NUTMEG PLACE, GERMANTOWN, MD 20874

20e. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

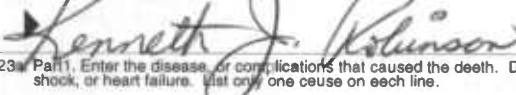
cemetery, crematory or other place)

FOREST HILL MEM. GDN. 7/26/97 CLINTON, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

PEYTON FUNERAL HOME

2205 S. SHIRLINGTON RD ARLINGTON, VA

23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. RUPTURE OF MYOCARDIUM

MINUTES

Due to (or as a consequence of):

b. ACUTE MYOCARDIAL INFARCTION

MINUTES

Due to (or as a consequence of):

c. RENAL FAILURE

Due to (or as a consequence of):

d. INSULIN DEPENDENT DIABETES MELLITUS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29e. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D29643

29d. Date signed (Month, Day, Year)

JULY 22, 1997

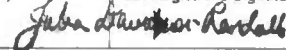
30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

STEVEN G. GEVAS, MD 8910 MEDICAL CENTER DRIVE, ROCKVILLE, MD 20850

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23845

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

KENNETH LEON TURNER

2. Date of Death

Month Day Year  
July 18, 1997

3. Time of Death

8:25 P.M.

4a. Facility Name (If not institution, give street and number)

PRINCE GEORGES HOSPITAL CENTER

4b. City, Town, or Location of Death

CHEVERLY

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

579-74-5023

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 10, 1957

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Palmer Park

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1832 Allendale Place

10f. Zip Code

20785

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Self Employed

17. Father's Name (First, Middle, Last)

Thomas H. Turner

18. Mother's Name (First, Middle, Maiden Surname)

Elouise Choice

19a. Informant's Name/Relationship (Type, Print)

Elouise Turner - Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1832 Allendale Place, Palmer Park, MD 20785

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Harmony Memorial Park

Date

7/26/97

20c. Location - City or Town, State

Landover, MD

21. Signature of Funeral Service Licensee

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, Inc.

4001 Benning Road, N. E., Washington, D. C.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.  
Shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. Sepsis  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Lastb. Pneumonia  
Due to (or as a consequence of):c. Renal Failure  
Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

2 days

2 days

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hepatitis C

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

James Catavinis, M.D.

29c. License number

D30318

29d. Date signed (Month, Day, Year)

7/20/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Catavinis, MD, 3001 Hospital Drive, Cheverly, Maryland 20785

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John A. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23846**  
Certificate of Death

Reg. No.

|   |   |   |  |   |  |  |   |   |  |
|---|---|---|--|---|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>SARAH P. TURNER</b>                        |   |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>15</b> Year <b>1997</b> |  | 3. Time of Death<br><b>2:54 AM</b>      |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Gilchrist Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Towson</b>                |  | 4c. County of Death<br><b>Baltimore</b> |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>577-40-9346</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs. | <input type="checkbox"/> Under 1 Year<br>Months Days  | <input type="checkbox"/> Under 24 Hrs.<br>Hours Min.                 | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 15, 1926</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Washington, DC</b> |  |
|   | Usual Residence of Decedent   |   |  |   |  |  |   |   |  |
| 10a. State<br><b>MD</b>   |   | 10b. County<br><b>Howard</b>  |  | 10c. City, Town or Location<br><b>Columbia</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |  |
| 10e. Street and Number<br><b>5141 Homecoming Lane</b>   |   |   |  | 10f. Zip Code<br><b>21044</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4 +</b> College (1-4or 5+) <b>4 +</b>   |   |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Educator</b>  |  | 16b. Kind of Business/Industry<br><b>P.G. County Schools</b>   |   |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Alexander H. Parker, Sr.</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Minnie Harrell</b>  |  |  |   |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wellington A. Turner - Husband</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5141 Homecoming Lane, Columbia, MD 21044</b>  |  |  |   |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>7-21-97 Suitland, MD</b>   |   |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |   |  | 22. Name and Address of Facility<br><b>Marshall's Funeral Home, Inc.<br/>4217 9th Street N.W. Washington, DC 20011</b>  |  |  |   |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic pancreatic cancer</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. _____</b><br>Due to (or as a consequence of):<br><b>c. _____</b><br>Due to (or as a consequence of):<br><b>d. _____</b> |   |   |  |   |  |  |   | Approximate Interval Between Onset and Death<br><b>6 months</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |   |  |
|   |   |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|   |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |  |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28d. Describe how Injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |  | 29c. License number<br><b>D25205</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 17, 1997</b>  |   |   |  |
| 29b. Signature and title of certifier<br>  |   |   |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>W. A. Riley, M.D. GBMC 6701 N. Charles Street Baltimore, MD 21204</b>  |  |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>   |   | 32. Registrar's Signature<br>                                  |  |   |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 24a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

In the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23847

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Muriel M. Tannahill

2. Date of Death

Month Day Year  
July 21, 1997

3. Time of Death

5:15AM

4a. Facility Name (If not institution, give street and number)

Doctors' Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

374 14 5609

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
May 11, 1920

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Bowie

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

3909 New Haven Court

10f. Zip Code

20716

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

Collegia (1-4 or 5+)

2

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Manager (Resident)

16b. Kind of Business/Industry

Bowie Commons

17. Father's Name (First, Middle, Last)

John Schreider

18. Mother's Name (First, Middle, Maiden Surname)

Sylvia Weiss

19a. Informant's Name/Relationship (Type, Print)

Vickie M. Dippel Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2405 Pittland Lane Bowie Maryland 20716

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

Roseland Park Cemetery July 25, 1997 Berkley Michigan

21. Signature of Funeral Service Licensee

*Michael L. Bigler*

22. Name and Address of Facility

Robert E. Evans Funeral Home, Inc.

16000 Annapolis Rd. Bowie Md. 20715

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of):

*Pneumonia*

b. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

*1 Month*

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Chronic obstructive lung Disease*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Dr. Michael L. Bigler*

29c. License number

D45660

29d. Date signed (Month, Day, Year)

7/22/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3060, Mitchellville Rd, Bowie MD 20716

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

*John Anderson-Randall*State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23848

Reg. No.

|                                     |  |  |   |   |  |  |  |  |
|-------------------------------------|--|--|---|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>JAMES FELIX TESTERMAN  |  |   |   | 2. Date of Death<br>Month Day Year<br>July 18 97   |  | 3. Time of Death<br>7:25 am  |  |
|                                     | 4a. Facility Name (If not institution, give street and number)<br>Bel Air Nursing & Rehabilitation Center  |  |   |   | 4b. City, Town, or Location of Death<br>Bel Air  |  | 4c. County of Death<br>Harford   |  |
| Funeral<br>Director                 | 5. Social Security Number<br>217-16-1948   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>91 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                           | 8. Date of Birth (Month, Day, Year)<br>Jan. 22, 1906   | 9. Birthplace (State or Foreign Country)<br>Virginia   |
|                                     | Usual Residence of Decedent  |  |   |   |  |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br>Maryland   |  | 10b. County<br>Harford  |   | 10c. City, Town or Location<br>Bel Air   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |
|                                     | 10e. Street and Number<br>2313 Calvary Road  |  |   |   | 10f. Zip Code<br>21015   |  | 10g. Citizen of What Country?<br>USA   |  |
|                                     | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 7 Collegia (1-4 or 5+)  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Carpenter   |  | 16b. Kind of Business/Industry<br>Construction   |  |
|                                     | 17. Father's Name (First, Middle, Last)<br>George Hamilton Testerman   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>America Vespucci Blevins  |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>Elizabeth Amrein - Daughter  |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>1103 Hendrix Court, Bel Air, MD 21014   |  |  |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Bel Air Memorial Gardens  |   | Date<br>7-22-97  | 20c. Location - City or Town, State<br>Bel Air, Maryland |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br><i>William K. McComas</i>   |  |   |   | 22. Name and Address of Facility<br>Howard K. McComas III Funeral Home, P.A.<br>1317 Cokesbury Rd., Abingdon, MD 21009   |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediata Causa (Final disease or condition resulting in death)<br>a. <i>PNEUMONIA</i><br>Due to (or as a consequence of):<br>b. <i>Metastatic Prostate CA</i><br>Due to (or as a consequence of):<br>c. <i>Coronary Artery Disease</i><br>Due to (or as a consequence of):<br>d. <i>COPD</i><br><br>Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |   |  |  |  |  |
|                                     | Approximate Interval Between Onset and Death<br>~7d<br>yrs.<br>yr<br>m   |  |   |   |  |  |  |  |
| Physician<br>/Medical<br>Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|                                     |  |  |   |   |  |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|                                     |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |
|                                     | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br>NA  |   | 28b. Time of Injury<br>NA M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|                                     |  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>NA  |   | 28d. Describe how Injury occurred<br>NA  |  |  |  |
|                                     |  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>NA   |  |  |  |
|                                     | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |  |  |  |
|                                     | 29b. Signature and title of certifier<br><i>Dr. [Signature]</i>  |  |   |   | 29c. License number<br>D 39889   |  | 29d. Date signed (Month, Day, Year)<br>7/19/97   |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>615 W. MACPHERSON RD BEL AIR MD 21014  |  |   |   |  |  |  |  |
| State<br>Registrar                  | 31. Date filed (Month, Day, Year)<br>2-2-1997  |  |   |   | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |  |

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23849

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|   |  |   |  |  |   |
|---|--|---|--|--|---|
| 1. Decedent's Name (First, Middle, Last)<br><b>WARREN STACY TUCKER</b>  |  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>20</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>3:35 AM</b>                          |
| 4a. Facility Name (If not Institution, give street and number)<br><b>Washington ADventist Hospital</b>  |  |   | 4b. City, Town, or Location of Death<br><b>Takoma Park</b>   |  | 4c. County of Death<br><b>Montgomery</b>                    |
| 5. Social Security Number<br><b>141-14-8843</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>Apr. 19, 1920</b> |
| 9. Birthplace (State or Foreign Country)<br><b>New York</b>   |  |   |  |  |   |
| 10a. State<br><b>VA</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Alexandria</b>   |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |
| 10e. Street and Number<br><b>4901 Seminary, Apt. 1603</b>   |  |   | 10f. Zip Code<br><b>22311</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                 |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>                              |  | 16b. Kind of Business/Industry<br><b>Federal Government</b> |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Tucker</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Helen Rapson</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Teresa Napoli</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>11429 Monterrey Drive, Silver Spring, MD 20902</b> |  |   |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>   |  | 20c. Location - City or Town, State<br><b>7/23/97 Alexandria, VA</b>   |   |
| 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>                     |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>Cardiopulmonary Arrest</b><br>Due to (or as a consequence of):<br><br>b. <b>Seizure Disorder</b><br>Due to (or as a consequence of):<br><br>c. <b>Altered Mental Status</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |  |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Anoxic Encephalopathy</b>  |  |   |  |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |   |
| 29b. Signature and title of certifier<br><b>G. Gupta, MD</b>  |  | 29c. License number<br><b>M 46398</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 20, 1997</b>  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>G. Gupta, MD 121 Congressional Lane, #409, Rockville, MD 20852</b>   |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>   |  | 32. Registrar's Signature<br>   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23850

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

STEPHANIE ANN THOMPSON

2. Date of Death

Month  
JULDay  
4Year  
1997

3. Time of Death

10:45 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NATIONAL NAVAL MEDICAL CENTER

4b. City, Town, or Location of Death

BETHESDA

4c. County of Death

MONTGOMERY

5. Social Security Number

214-48-9385

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

50

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

September 10, 1946 Maryland

9. Birthplace (State or Foreign Country)

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Great Mills

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

45746 Nancy Lane

10f. Zip Code

20634

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

U.S. Navy/Defense

17. Father's Name (First, Middle, Last)

Thomas Frederick Rosewag

18. Mother's Name (First, Middle, Maiden Surname)

Camilla Agnes Beall

19a. Informant's Name/Relationship (Type, Print)

Barbara Goldsborough, Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45746 Nancy Lane, Great Mills, Maryland 20634

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Metropolitan Crematory

Date

7-8-1997

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Service Licensee

Michael K. Blankenship, M00852

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, Maryland 20650-0279

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. METASTATIC MELANOMA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David L. Blazes MD

29c. License number

D-51503

29d. Date signed (Month, Day, Year)

07 July 97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DAVID L. BLAZES, LT, MC, USN

NATIONAL NAVAL MEDICAL CENTER

BETHESDA MD 20889-5600

31. Date filed (Month, Day, Year)

JUL - 9 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23851

Reg. No.

|  |   |  |   |   |  |   |   |  |
|--|---|--|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MAGGIE ESTELLE Todd</b>  |  |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>24</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>1225 pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Dorchester General Hospital</b>  |  |   |   | 4b. City, Town, or Location of Death<br><b>Cambridge</b>   |   | 4c. County of Death<br><b>Dorchester</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-16-8870</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (in yrs. last birthday)<br><b>86</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan 01 1911</b>   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |
|  | Usual Residence of Decedent   |  |   |   |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD</b>   | 10b. County<br><b>Dorchester</b>   |   | 10c. City, Town or Location<br><b>Cambridge</b>   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No        |  |
|  | 10e. Street and Number<br><b>525 Glenburn Ave.</b>  |  |   | 10f. Zip Code<br><b>21613</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>white</b>                               |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>crab picker</b>                   |   |  | 16b. Kind of Business/Industry<br><b>seafood processing</b>                                 |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Emory Moore</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Laura Hughes</b>   |   |   |  |
| To Be Completed by Physician/Medical Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Robert C. Todd - son</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2 Bayview Ave., Cambridge, MD 21613</b>  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>East New Market Cemetery</b>   |   | Date<br><b>7-26-97</b>   |   | 20c. Location - City or Town, State<br><b>East New Market, MD</b>                                     |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Kenneth R. Thomas</b>   |  |   |   | 22. Name and Address of Facility<br><b>Thomas Funeral Home PA<br/>700 Locust St. Cambridge, MD 21613</b>   |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Myocardial Infarction</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |   |   | Approximate Interval Between Onset and Death<br><b>9 Days</b>  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |  |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) |   |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |  |   |   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>William Bair</b>   |   |  |   | 29c. License number<br><b>D43238</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>July 24 1997</b>                                  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>19 Franklin St. Cambridge, MD 21613 / William Bair</b>  |   |  |   |   |  |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>  |   | 32. Registrar's Signature<br><b>John Davidson-Randall</b>                              |   |   |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23852

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Aubrey Roger Taylor

2. Date of Death

Month Day Year  
July 19, 1997

3. Time of Death

9:15 am

4a. Facility Name (If not institution, give street and number)

39 W. Deep Run Road

4b. City, Town, or Location of Death

Westminster

4c. County of Death

Carroll

Funeral  
Director

5. Social Security Number

214-40-0560

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

57 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
March 29, 1940

9. Birthplace (State or Foreign Country)

Tennessee

Usual Residence of Decedent

10a. State

MD

10b. County

Carroll

10c. City, Town or Location

Westminster

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

39 W. Deep Run Road

10f. Zip Code

21158

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates: 1961-196513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

worker

16b. Kind of Business/Industry

G.M. Parts Div.

17. Father's Name (First, Middle, Last)

Aubrey Jennings Taylor

18. Mother's Name (First, Middle, Maiden Surname)

Lora Avie Cantrell

19a. Informant's Name/Relationship (Type, Print)

Dorothy Ann Taylor, wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

39 W. Deep Run Rd., Westminster, MD 21158

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Garrison Forest Cemetery

Date

07/23/97

20c. Location - City or Town, State

Owings Mills, MD

21. Signature of Funeral Service Licensee

Kathleen Pritz - Surdyk

22. Name and Address of Facility

Pitts Funeral Home &amp; Chapel

412 Washington Rd., Westminster, MD 21157

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. COLON Cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 months

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Norman Goldstein

29c. License number

D26385

29d. Date signed (Month, Day, Year)

7-21-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Norman Goldstein 218 Wasington Heights Medical Center, Westminster MD 21157

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

John Anderson Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





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State of Maryland / Department of Health and Mental Hygiene

97 23853

## Certificate of Death

Reg. No.

|   |   |  |   |  |   |  |   |  |
|---|---|--|---|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARJORIE LOUISE TONEY</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 20 1997</b>   |  | 3. Time of Death<br><b>5:48 p.m.</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PHYSICIANS MEMORIAL HOSPITAL</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>LA PLATA</b>   |  | 4c. County of Death<br><b>CHARLES</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>578-40-2006</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JANUARY 9, 1931</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>NORTH CAROLINA</b>   |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>CHARLES</b>   |  | 10c. City, Town or Location<br><b>WALDORF</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>2928 EUTAW FOREST DRIVE</b>  |  | 10f. Zip Code<br><b>20603</b>   |  | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                                   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (13-16) <b>0</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ACTIVITIES AIDE</b>   |  | 16b. Kind of Business/Industry<br><b>NURSING HOME</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ORVILLE DEWEY KEENE</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>WRAY C. HALL</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>SHERRI LITZ - DAUGHTER</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>15972 MEANDERING DRIVE, BRANDYWINE, MD 20613</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>TRINITY MEM. GARDENS JULY 24, 1997 WALDORF, MARYLAND</b>   |  | 20c. Location - City or Town, State   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>MARK G. BROHAWN M00053</b>  |  | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC.<br/>P.O. BOX 156, WALDORF, MARYLAND 20604</b>   |  |   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or instant fatality. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Sepsis</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Cerebrovascular Accident</b><br><b>Dehydration</b> |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  |
|   | 28b. Time of Injury<br>M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                              |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D-46419</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/21/97</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>CHARLENE LETCHFORD M.D. 700 OLD LINE CENTER SUITE 100 WALDORF MARYLAND 20602</b>   |  | 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

97 23854

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |   |  |
|--|---|---|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JULIA COX TOTTEN</b>                                     |   |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>21</b> Year <b>1997</b> |  | 3. Time of Death<br><b>10:56 AM</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>              |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                              |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>220-36-6268</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>79</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPTEMBER 26, 1917 MARYLAND</b> |  |
|  | Usual Residence of Decedent   |   | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>CHARLES</b>  |  | 10c. City, Town or Location<br><b>WHITE PLAINS</b>                        |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>4900 CRAIN HIGHWAY</b>   |  | 10f. Zip Code<br><b>20695</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY TO SUPERINTENDENT</b>   |  | 16b. Kind of Business/Industry<br><b>CHARLES COUNTY BOARD OF EDUCATION</b>   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JAMES ARTHUR COX</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNA CECILIA MUDD</b>  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMES D. COX/BROTHER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>9995 MARSHALL CORNER ROAD, WHITE PLAINS, MD 20695</b>  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CEDAR HILL CEMETERY</b>  |  | Date<br><b>7/25/1997</b>   |  | 20c. Location - City or Town, State<br><b>SUITLAND, MARYLAND</b>   |   |  |
| 21. Signature of Funeral Service Licensee<br><b>MARK G. BROHAWN</b>  |   | 22. Name and Address of Facility<br><b>THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX 156, WALDORF, MARYLAND 20604-0156</b>  |  |  |  |  |   |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | e. <b>Spinal Shock</b><br>Due to (or as a consequence of):<br><br>b. <b>C<sub>1</sub>-C<sub>2</sub> Dislocation</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):   |  | Approximate Interval Between Onset and Death<br><b>Approx. 1-2 days</b>  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |   |  |
|  |   |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |
|  |   |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>7-15-97</b>  |  | 28b. Time of Injury<br><b>02:10 PM</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>   |  | 28d. Describe how injury occurred<br><b>DRIVER OF AUTO VS AUTO COLLISION</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>RT 301 &amp; MITCHELL RD, WHITE PLAINS MARYLAND</b> |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.               |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D30318</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>7/22/97</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>DR. JAMES CATAVENIS, 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>  |   |   |  |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>  |   | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23855

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Jennifer Onyemaechi Udegbe   |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>July 14, 1997  |  | 3. Time of Death<br>9:45 PM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Holy Cross Hospital  |  |   |  |  |  | 4b. City, Town, or Location of Death<br>Silver Spring  |  | 4c. County of Death<br>Montgomery  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>None  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>Yrs. Months Days<br>1 26   |  | 8. Date of Birth (Month, Day, Year)<br>July 14, 1997   |  | 9. Birthplace (State or Foreign Country)<br>Maryland   |  |
|   | 10a. State<br>Maryland   |  | 10b. County<br>Prince George's  |  | 10c. City, Town or Location<br>Greenbelt   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br>7708 Hanover Parkway, #T-3   |  |   |  | 10f. Zip Code<br>20770   |  | 10g. Citizen of What Country?<br>United States   |  |  |  |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: Black   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4or 5+)<br>0   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>None  |  | 16b. Kind of Business/Industry<br>None   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Harry M. Udegbe   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Franca Onunkwo  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>Franca Onunkwo-Udegbe  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Same as 10  |  |  |  |  |  |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Chesapeake Crematory  |  | Date<br>7-16-97  |  | 20c. Location - City or Town, State<br>Beltsville, Maryland  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Ellen H. Rapp   |  |   |  | 22. Name and Address of Facility<br>Rapp Funeral Services, P. A.<br>933 Gist Avenue, Silver Spring, MD 20910   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. EXTREME PREMATUREITY<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  | Approximate Interval Between Onset and Death<br>1 1/2 Hrs  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   |  |  |   |  |  |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>J. Davidson-Randall  |  | 29c. License number<br>D20524  |  | 29d. Date signed (Month, Day, Year)<br>7/14/97   |  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>STEVEN LORRIS MD, HOLY CROSS HOSPITAL, 1500 FOREST GLEN RD, SILVER SPRING, MD 20910  |  |   |  |  |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JUL 21 1997   |  |   |  | 32. Registrar's Signature<br>J. Davidson-Randall   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23856

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Ann Utterback

2. Date of Death

Month Day Year  
July 17, 1997

3. Time of Death

9:00 pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Calvert Memorial Hospital

4b. City, Town, or Location of Death

Prince Frederick Calvert

4c. County of Death

Calvert

5. Social Security Number

578-42-0122

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 30, 1932

9. Birthplace (State or Foreign Country)

Washington, DC

Usual Residence of Decedent

10a. State

Maryland Anne Arundel

10b. County

10c. City, Town or Location

Lothian

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

96 A Street Lyons Creek

10f. Zip Code

20711

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

Private Industry

17. Father's Name (First, Middle, Last)

Clarence Landon Best

18. Mother's Name (First, Middle, Maiden Surname)

Lillie Margaret Best

19a. Informant's Name/Relationship (Type, Print)

Thomas Utterback, Sr. - Spouse

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

96 A Street Lyons Creek, Lothian, Maryland 20711

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Columbia Memorial Park

Date

07/22/97

20c. Location - City or Town, State

Columbia, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Francis Gasch's Sons Funeral Home, P.A.

4739 Baltimore Avenue, Hyattsville, MD 20781

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Upper Gastrointestinal Bleeding

Due to (or as a consequence of):

60 Minutes

b. Peptic Ulcer Disease

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary Artery Disease

Diabetes Mellitus

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D26358

29d. Date signed (Month, Day, Year)

JULY 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John H. Weigel, M.D. 120 Hospital Road #200, Prince Frederick, Maryland 20678-4020

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23857

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charlotte M. Varron

2. Date of Death

Month Day Year  
July 20, 1997

3. Time of Death

12:45pm.

4a. Facility Name (If not institution, give street and number)

Doctors Community Hospital

4b. City, Town, or Location of Death

Lanham

4c. County of Death

Prince Georges

Funeral  
Director

5. Social Security Number

579-24-9518

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

71

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
April 3, 1926

9. Birthplace (State or Foreign Country)

North Carolina

Usual Residence of Decedent

10e. State

Maryland

10b. County

Prince Georges

10c. City, Town or Location

Riverdale

10d. Inside City Limits

☒ Yes 2 ☐ No

10e. Street and Number

6802 Emerson Street

10f. Zip Code

20737

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
Caucasian15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Telephone Operator

16b. Kind of Business/Industry

C &amp; P Telephone

17. Father's Name (First, Middle, Last)

Bergon V. Sigmond

18. Mother's Name (First, Middle, Maiden Sumame)

Unknown

19a. Informant's Name/Relationship (Type, Print)

Tony Varron-Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6802 Emerson Street, Riverdale, MD 20737

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Cedar Hill Cemetery

Date

July 23,  
1997

20c. Location - City or Town, State

Suitland, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Rendon/Hale Funeral Home  
9013 Annapolis Road, Lanham, MD 2070623a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. *Cardiogenic Shock*  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

12 hrs

b. *Myocardial Infarction*  
Due to (or as a consequence of):

12 hrs

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastc. *Arteriosclerotic Cardiovascular Disease*  
Due to (or as a consequence of):

10 yrs

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Diabetes**Measles**I**COPD*

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DCA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

PL6197

29d. Date signed (Month, Day, Year)

7-21-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANDRES C. LARA, MD - 932 Lombard-Savage Rd. Lanham, MD 20706

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23858

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |  |  |
|---|---|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>John Lemuel Windsor   |  |   |  | 2. Date of Death<br>Month Day Year<br>July 23, 1997  |  | 3. Time of Death<br>1:00 am  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Prince George's Hospital Center   |  |   |  | 4b. City, Town, or Location of Death<br>Cheverly   |  | 4c. County of Death<br>Prince George's   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>577-18-5416  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>81 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Jan. 21, 1916   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Maryland  |  | 10. Usual Residence of Decedent<br>10a. State<br>Maryland   |  | 10b. County<br>Prince George's   |  | 10c. City, Town or Location<br>Capitol Heights   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>9504 Beech Park Street  |  | 10f. Zip Code<br>20743   |  | 10g. Citizen of What Country?<br>U.S.A.  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>6   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Grader Worker  |  | 16b. Kind of Business/Industry<br>Department of Public Works   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>Aubrey Windsor   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Maggie Hutchinson   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br>Pauline Windsor - Wife  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>9504 Beech Park Street, Capitol Heights, MD 20743   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Fort Lincoln Cemetery   |  | 20c. Location - City or Town, State<br>Brentwood, Maryland   |  | 20d. Date<br>07/26/97  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Nancy J. Thompson  |  |   |  | 22. Name and Address of Facility<br>Francis Gasch's Sons Funeral Home, P.A.<br>4739 Baltimore Avenue, Hyattsville, MD 20781  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. RESPIRATORY FAILURE<br>Due to (or as a consequence of):<br>b. CHRONIC OBSTRUCTIVE PULMONARY DISEASE<br>Due to (or as a consequence of):<br>c. CONDUCTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>d. |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DIABETES MELLITUS   |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>John M. De La Baume  |  |   |  | 29c. License number<br>MD D34498   |  | 29d. Date signed (Month, Day, Year)<br>JULY 23, 1997   |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>HENRI BENN DE LA BAUME 7700 OLD BRANCH AVE, CAPITOL HEIGHTS, MD   |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>JUL 25 1997  |  |   |  | 32. Registrar's Signature<br>John M. De La Baume   |  |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23859

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ARCHIE WALKER

2. Date of Death

Month  
JULYDay  
10Year  
1997

3. Time of Death

7:10 pm

Funeral  
Director

4e. Facility Name (If not institution, give street and number)

FORT WASHINGTON HOSPITAL

4b. City, Town, or Location of Death

FORT WASHINGTON

4c. County of Death

PRINCE GEORGE'S

5. Social Security Number

423-05-3895

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

81

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
Oct. 30, 1915

9. Birthplace (State or Foreign Country)

Pittsview, AL

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Clinton

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

8826 Creekway Drive

10f. Zip Code

20735-4611

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Steel Worker

16b. Kind of Business/Industry

Private

17. Father's Name (First, Middle, Last)

John Walker

18. Mother's Name (First, Middle, Maiden Surname)

Daisy D. Scott

19a. Informant's Name/Relationship (Type, Print)

Nelson Hughes - Son-in-Law

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8826 Creekway Drive, Clinton, MD 20735

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Maryland National Memorial Park 7/18/97

Date

20c. Location - City or Town, State

Laurel, MD

21. Signature of Funeral Service Licentiate

John T. Stewart III

22. Name and Address of Facility

STEWART FUNERAL HOME, INC.

4001 Benning Road, N.E., Washington, D. C. 20019

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiac Arrhythmia

Due to (or as a consequence of):

b. Coronary Artery Disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of injury

(Month, Day, Year)

28b. Time of injury

M

28c. Injury at work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Stewart III

29c. License number

D26352

29d. Date signed (Month, Day, Year)

July 19, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HAYE 9131 Piscataway Rd Clinton md

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

John T. Stewart III

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-358-0000.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



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State of Maryland / Department of Health and Mental Hygiene 97 23860

STACY WHEATLEY

## Certificate of Death

Reg. No.

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>STACY NOEL WHEATLEY</b>  |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>13</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>3:41 PM</b>   |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>   |   | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>   |   | 4c. County of Death<br><b>PRINCE GEORGES</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>579-96-5314</b>   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>20</b> Yrs.  | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   |
|   | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 30, 1977</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Washington, D.C.</b>   |   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent   |   |   |   |  |
|   | 10e. State<br><b>MD</b>   | 10b. County<br><b>P.G.</b>  | 10c. City, Town or Location<br><b>Oxon Hill</b>   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |
|   | 10e. Street and Number<br><b>6417 Livingston Rd.</b>  |   | 10f. Zip Code<br><b>20745</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>none</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>none</b>                              |   | 16b. Kind of Business/Industry<br><b>None</b>  |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Thomas Humphries</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Brenda Wheatley</b>   |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Brenda Wheatley mother</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6417 Livingston Rd. Oxon Hill Md.</b>             |   |  |
|   | 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Harmony Mem. Park</b>  |   | 20c. Location - City or Town, State<br><b>7/19/97 Landover Maryland</b>  |
|   | 21. Signature of Funeral Service Licensee<br><b>Janice Edwards</b>  |   | 22. Name and Address of Facility<br><b>Hodges and Edwards<br/>3910 Silver Hill RD. Suitland, Md. 20746</b>  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                                       |   |   |   |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Gunshot wound of the head</b><br>Due to (or as a consequence of):<br>b. _____ Due to (or as a consequence of):<br>c. _____ Due to (or as a consequence of):<br>d. _____  |   |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown<br>24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>7-13-97</b>  |   |   |  |
| 28b. Time of Injury<br><b>1505 M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Home</b>   |   | 28d. Describe how injury occurred<br><b>Subject was shot</b>  |   |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Cindy Lane #304 Seat Pleasant, Maryland</b>  |   |   |   |   |  |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |   |   |   |  |
| 29b. Signature and title of certifier<br><b>Stephen S. Radentz, MD</b>  |   | 29c. License number<br><b>O.C.M.E.</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 14, 1997</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Stephen S. Radentz 111 Penn Street, Baltimore, Maryland 21201</b>  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 21 1997</b>   |   | 32. Registrar's Signature<br><b>John A. Radentz</b>   |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





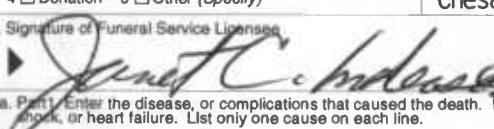
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23861

## Certificate of Death

Reg. No.

|  |   |   |  |  |  |  |   |  |  |
|--|---|---|--|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES EDWARD WILSON</b>                                  |   |  |  | 2. Date of Death<br>Month <b>JULY</b> Day <b>15</b> Year <b>1997</b> |  | 3. Time of Death<br><b>06:12 PM</b>                             |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>              |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>113-14-1583</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                     |  | 8. Date of Birth (Month, Day, Year)<br><b>December 21, 1923</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>   |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Prince George's</b>                                |  | 10c. City, Town or Location<br><b>Capitol Heights</b>           |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>505 Suffolk Avenue #219</b>   |  | 10f. Zip Code<br><b>20743</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b> |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Foreman</b>   |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |  |   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Paul Wilson</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Dacey Wilson</b>   |  |  |   |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Debra A. Wilson (Wife)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>505 Suffolk Avenue #219 Capitol Heights, Maryland 20743</b>                              |  |  |   |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Chesapeake Crematory, Inc.</b>   |  | Date<br><b>7/19/97</b>   |  | 20c. Location - City or Town, State<br><b>Beltsville, Maryland</b>   |   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Rollins Funeral Home, Inc.<br/>4339 Hunt Place, N.E. Washington, D.C. 20019</b>   |  |  |   |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):  |   |   |  |  |  |  |   | Approximate Interval Between Onset and Death   |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br><b>b.</b> Due to (or as a consequence of):<br><b>c.</b> Due to (or as a consequence of):<br><b>d.</b> Due to (or as a consequence of):   |   |   |  |  |  |  |   |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |  |
|  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |  |
|  |   |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |   |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred              |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br> DME  |  | 29c. License number<br><b>D 33954</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 16, 1997</b>  |   |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MARIO F. GOLIVE JR. MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>  |   |   |  |  |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 21 1997</b>  |   | 32. Registrar's Signature<br>  |  |  |  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23862

JAMES WARD

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |   |   |  |  |  |  |  |  |   |
|--|---|--|---|--|--|--|---|---|--|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>James F. Ward</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 20 1997</b>  |  |   | 3. Time of Death<br><b>7:00 PM</b>                                      |  |  |  |  |  |  |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>PRINCE GEORGES HOSPITAL CENTER</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>CHEVERLY</b>  |  |   | 4c. County of Death<br><b>PRINCE GEORGES</b>                            |  |  |  |  |  |  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>239 22 4354</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (in yrs. last birthday)<br><b>77</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov 13, 1919</b>                                  |   | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |  |  |  |  |  |   |
|  | Usual Residence of Decedent   |  |   |  |  |  |   |   |  |  |  |  |  |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>VA</b>   |  | 10b. County<br><b>none</b>  |  | 10c. City, Town or Location<br><b>Alexandria</b>   |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |  |  |   |
|  | 10e. Street and Number<br><b>1521 Princess Street</b>   |  |   |  | 10f. Zip Code<br><b>22314</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |  |  |  |  |  |   |
|  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b> |  |  |  |  |  |  |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Food Preparation</b>   |  |   | 16b. Kind of Business/Industry<br><b>Airline Caterer</b>                |  |  |  |  |  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Ward Jr</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Hattie Best</b>  |  |   |   |  |  |  |  |  |  |   |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br><b>James Ward son</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1907 Mystic Ave Oxon Hill, Md 20745</b>  |  |   |   |  |  |  |  |  |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Coleman Cemetery</b>   |  | Data<br><b>7/25/97</b>   |  | 20c. Location - City or Town, State<br><b>Fairfax Co., VA</b>                               |   |  |  |  |  |  |  |   |
|  | 21. Signature of Funeral Service Licensee<br><b>Dennis J. Chute</b>   |  |   |  | 22. Name and Address of Facility<br><b>GREENE FUNERAL HOME<br/>814 Franklin Street<br/>Alexandria, VA 22314</b>  |  |   |   |  |  |  |  |  |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Head Injuries</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |   |   |  |  | Approximate Interval Between Onset and Death   |  |  |  |   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |  |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br><b>7/20/97</b>  |  | 28b. Time of Injury<br><b>4:00 P M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred<br><b>Subject fell down steps</b>                            |  |  |  |  |  |   |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>HOME</b>   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>8202 ALCOA DR. OXON HILL MARYLAND</b>   |  |   |   |  |  |  |  |  |  |   |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |   |   |  |  | 29b. Signature and title of certifier<br><b>Dennis J. Chute MD</b>   |  | 29c. License number<br><b>O.C.M.E.</b> |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 21, 1997</b> |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |  |   |   |  |  |  |  |  |  |   |
|  | 31. Date filed (Month, Day, Year)<br><b>JUL 23 1997</b>   |  |   |  | 32. Registrar's Signature<br><b>Juba Davis-Rodriguez</b>   |  |   |   |  |  |  |  |  |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23863

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CLEMENTINE

2. Date of Death

July 20 1997

Day

Year

3. Time of Death

12:47 PM

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY COUNTY

Funeral  
Director

5. Social Security Number

578-29-5705

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

75

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

06-12-22

9. Birthplace (State or Foreign Country)

DC

Usual Residence of Decedent

10a. State

MD

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

☒ Yes ☐ No

10a. Street and Number

307 University Blvd W.

10f. Zip Code

20901

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

DC Government

17. Father's Name (First, Middle, Last)

Andrew Price

18. Mother's Name (First, Middle, Maiden Surname)

Clara Jupiter

19a. Informant's Name/Relationship (Type, Print)

Nathaniel Price Sr./Brother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9117 Glenville Rd, Silver Spring, MD. 20901

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glenwood Cemetery

Date

07/25

20c. Location - City or Town, State

Washington, DC

21. Signature of Funeral Service Licensee

EDWARD M. DUDLEY

22. Name and Address of Facility

DUDLEY FUNERAL HOME

3200 R.I. AVE., MT. RAINIER, MARYLAND 20712

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of)

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

40 min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMER'S DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☒ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of injury (Month, Day Year)

28b. Time of injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

208546

29d. Date signed (Month, Day, Year)

July 20 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

John T. Tucker

8218 Wisconsin Ave Bethesda

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

John T. Tucker

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

State  
Registrar



97 23864

Reg. No.





KEVIN ANDRE WADDY

Items: 23a part 1.27 per MEO G-750 8/19/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23865

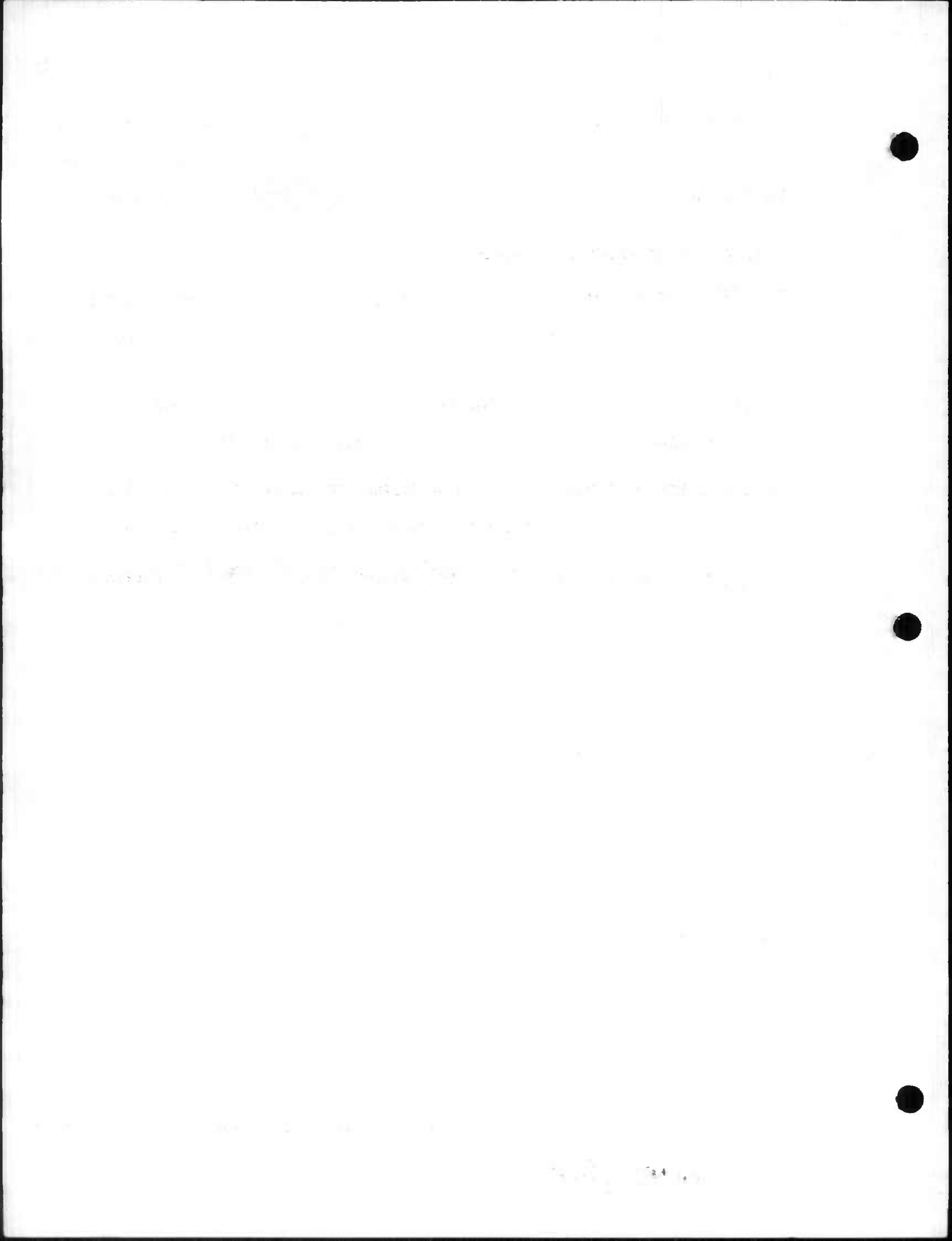
Reg. No.

|  |  |   |  |  |   |   |   |   |
|--|--|---|--|--|---|---|---|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>KEVIN ANDRE WADDY</b>                         |   |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 23 1997</b> |   | 3. Time of Death<br><b>7:45 P</b>                           |   |
|  | 4e. Facility Name (If not Institution, give street and number)<br><b>BOWIE HEALTH CENTER</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BOWIE</b>      |   | 4c. County of Death<br><b>PRINCE GEORGES</b>                |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-78-5754</b>  |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.          |   | 8. Date of Birth (Month, Day, Year)<br><b>JULY 17, 1956</b> |   |
|  | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON, D.C.</b>                          |   |  |  |   |   |   |   |
| Usual Residence of Decedent  |  |   |  |  |   |   |   |   |
| 10e. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>PRINCE GEORGE'S</b>   |  | 10c. City, Town or Location<br><b>BOWIE</b>  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |   |
| 10e. Street and Number<br><b>2205 PRINCE WHALES CT.</b>  |  |   |  | 10f. Zip Code<br><b>20716</b>  |   | 10g. Citizen of What Country?<br><b>UNITED STATES</b>   |   |   |
| 11. Marital Status<br>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>   |   |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9TH</b> College (1-4 or 5+)  |  |   |  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DISABLED</b>  |   | 16b. Kind of Business/Industry<br><b>N/A</b>  |   |   |
| 17. Father's Name (First, Middle, Last)<br><b>BENJAMIN WADDY</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>HATTIE R. BEASLEY</b>  |   |   |   |   |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>HATTIE R. BEASLEY/MOTHER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1914 SHADYSIDE AVE. SUITLAND, MARYLAND 20746</b>   |   |   |   |   |
| 20e. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MARYLAND NATIONAL CEM.</b>   |  | Date<br><b>7/28/97</b>   |   | 20c. Location - City or Town, State<br><b>LAUREL, MD.</b>   |   |   |
| 21. Signature of Funeral Service Licensee<br><i>Kent G. Sarge M1085</i>  |  |   |  | 22. Name and Address of Facility<br><b>ALEXANDER S. POPE FUNERAL HOMES<br/>5538 MARLBORO PIKE/FORESTVILLE, MARYLAND 20747</b>  |   |   |   |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>SEIZURE DISORDER</b><br>Due to (or as a consequence of):<br><br>b. _____<br>Due to (or as a consequence of):<br><br>c. _____<br>Due to (or as a consequence of):<br><br>d. _____ |  |   |  |  |   |   |   | Approximate Interval Between Onset and Death  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |
|  |  |   |  |  |   | 24e. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |  |  |   |   |   |   |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred   |
|  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |
| 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  | 29b. Signature and title of certifier<br><i>Dennis J. Chute MD</i>  |  | 29c. License number<br><b>O.C.M.E</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 24, 1997</b>   |   |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dennis J. Chute MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |  |  |   |   |   |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL 30 1997</b>  |  | 32. Registrar's Signature<br><i>John Davidson Randall</i>   |  |  |   |   |   |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23866

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LAWRENCE WALTON WIMMER

2. Date of Death

Month Day Year  
July 21, 1997

3. Time of Death

4:00 PM

4a. Facility Name (If not institution, give street and number)

1333 Old Fallston Road

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

213-01-9922

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 22, 1910

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Fallston

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1333 Old Fallston Road

10f. Zip Code

21047

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
7

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Mechanic

16b. Kind of Business/Industry

Appliance

17. Father's Name (First, Middle, Last)

William (u/k) Wimmer

18. Mother's Name (First, Middle, Maiden Surname)

Cora Elizabeth Walton

19a. Informant's Name/Relationship (Type, Print)

Marguerite I. Wimmer, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1333 Old Fallston Road, Fallston, Maryland 21047

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Fallston Methodist Ch. Cem. 7/24/97 Fallston, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Road, Abingdon, Maryland 2100923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

Carcinoma of Lung and  
Severe anemiaApproximate  
Interval Between  
Onset and Death

6 mos

b.

Due to (or as a consequence of):

6 mos.

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☒ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☐ Yes ☐ No

26. Place of Death (Check only one)

Hospital:

☐ Inpatient☐ ER/Outpatient☐ DOA

Other:

☐ Nursing Home☒ Residence☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D.16444

29d. Date signed (Month, Day, Year)

JULY-22nd 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

VIJAY S. NAIR M.D. 2112 BELAIR ROAD: FALLSTON, MD 21047

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23867

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HOWARD TAFT WILLIAMS

2. Date of Death

Month Day Year  
July 16, 1997

3. Time of Death

10:10PM

4a. Facility Name (If not institution, give street and number)

VA Maryland Health Care System

4b. City, Town, or Location of Death

Perry Point

4c. County of Death

Cecil

Funeral  
Director

5. Social Security Number

229-26-3345

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

87 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Nov. 20, 1909

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Joppa

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

1903 Philadelphia Road

10f. Zip Code

21085

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☒ Married  
☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☒ Yes ☐ No  
If Yes, Give  
Year or Dates: 1943-4513. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

1

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contract Specialist

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

Rial Martin Williams

18. Mother's Name (First, Middle, Maiden Surname)

Emily Alverda Lane

19a. Informant's Name/Relationship (Type, Print)

Kathryn R. Williams - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1903 Philadelphia Rd., Joppa, MD 21085

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Bel Air Memorial Gardens

Data

7-22-97

20c. Location - City or Town, State

Bel Air, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Howard K. McComas III Funeral Home, P.A.  
1317 Cokesbury Rd., Abingdon, MD 2100923a. Part I. Enter the disease, or complications they caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Respiratory Failure due to Cerebrovascular Accident

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

4 hours

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes mellitus

Coronary artery disease

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☐ No25. Was case referred to medical  
examiner?  
☐ Yes ☒ No

Hospital:

☐ Inpatient ☐ ER/Outpatient ☐ DOA

26. Place of Death (Check only one)

Other:

☒ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicidal ☐ Homicidal28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D20215

29d. Date signed (Month, Day, Year)

July 16, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARMACHANDRA NAIR, M.D. VA Maryland Health Care System, Perry Point, MD 21902

31. Date filed (Month, Day, Year)

JUL 18 1997

32. Registrar's Signature

State  
RegistrarHOWARD TAFT WILLIAMS  
Baltimore, Maryland 21215-0020Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23868

## Certificate of Death

Reg. No.

|  |  |  |   |   |  |  |  |  |  |  |
|--|--|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Orville Kenneth Wright   |  |   |   | 2. Date of Death<br>Month Day Year<br>July 17, 1997  |  |  |  | 3. Time of Death<br>1:02am                           |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>SHADY GROVE ADVENTIST HOSPITAL   |  |   |   | 4b. City, Town, or Location of Death<br>ROCKVILLE  |  |  |  | 4c. County of Death<br>MONTGOMERY                    |  |
| Funeral<br>Director  | 5. Social Security Number<br>217-44-0043   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br>83 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 25, 1914                                 |  | 9. Birthplace (State or Foreign Country)<br>Oklahoma |  |
|  | Usual Residence of Decedent  |  |   |   | 10a. State<br>Maryland   |  | 10b. County<br>Montgomery  |  | 10c. City, Town or Location<br>Gaithersburg          |  |
| To Be Completed by Funeral Director                                  | 10e. Street and Number<br>409 Christopher Avenue #24   |  |   |   | 10f. Zip Code<br>20879   |  | 10g. Citizen of What Country?<br>United States                                       |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:        |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                     |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+) 5+  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Executive Officer  |   | 16b. Kind of Business/Industry<br>Federal Government   |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>James Edwin Wright  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Charity Jane Wisdom   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Elizabeth H. Wright (Wife)   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>409 Christopher Avenue #24, Gaithersburg, MD 20879  |  |  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metropolitan Crematory  |   | 20c. Date<br>7/18/97   |  | 20d. Location - City or Town, State<br>Alexandria, Virginia                          |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br>DeVol Funeral Home<br>10 East Deer Park Drive<br>Gaithersburg, MD 20877  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. Acute Myocardial Infarction<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. |  |   |   | Approximate Interval Between Onset and Death<br>1 Day  |  |  |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown |  |  |  |  |  |
|  |  |  |   |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |
|  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred                    |  |
|  |  |  | 28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)         |  |  |  |
|  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br>  |   | 29c. License number<br>D 29300   |  | 29d. Date signed (Month, Day, Year)<br>July 22, 1997                                 |  |  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Robert L. Gold 15225 Shady Grove Road, Rockville, MD   |  |   |   |  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br>JUL 23 1997   |  | 32. Registrar's Signature<br>  |   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23869

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Edith

Wolff

2. Date of Death

Month Day Year  
JULY 18, 1997

3. Time of Death

6:30PM

4a. Facility Name (If not institution, give street and number)

HEBREW HOME OF GREATER WASHINGTON

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

060-26-9021

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

90 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 7, 1907

9. Birthplace (State or Foreign Country)

GERMANY

Usual Residence of Decedent

10a. State

MD

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

6121 MONTROSE RD.

10f. Zip Code

20852

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

BOOKKEEPER

16b. Kind of Business/Industry

COMMERCE

17. Father's Name (First, Middle, Last)

JULIUS KLEPETAR

18. Mother's Name (First, Middle, Maiden Surname)

JENNY GRAETZER

19a. Informant's Name/Relationship (Type, Print)

JOHN H. WOLFF / SON

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8228 LAKENHEALTH WAY, ROCKVILLE, MD 20854

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

UNION FIELD CEMETERY

Date

7/21/97

20c. Location - City or Town, State

BROOKLYN, NY

21. Signature of Funeral Service Licensee

DANIEL SIMONS

22. Name and Address of Facility

EDWARD SAGEL FUNERAL DIRECTION, INC.  
1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

ALZHEIMER'S DISEASE

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

5 yrs

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

D33224

JULY 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

RAM TREHAN 50 W EDMONSTON DR, ROCKVILLE MD 20852

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Jana Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23870

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |  |  |  |
|--|--|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>EVELYN BALDWIN WILLIAMS  |  |  |  | 2. Date of Death<br>Month Day Year<br>July 7 1997   |  | 3. Time of Death<br>11:55AM  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>PRINCE GEORGES HOSPITAL  |  |  |  | 4b. City, Town, or Location of Death<br>CHEVERLY  |  | 4c. County of Death<br>PRINCE GEORGES  |  |
| Funeral<br>Director  | 5. Social Security Number<br>579-74-3719   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>40 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>1-21-1957   |  |
|  | 9. Birthplace (State or Foreign Country)<br>WASHINGTONDC   |  | 10a. State<br>MD   |  | 10b. County<br>PRINCE GEORGES   |  | 10c. City, Town or Location<br>HYATTSVILLE   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br>2515 AVALON PLACE   |  | 10f. Zip Code  |  |
|  | 10g. Citizen of What Country?<br>USA   |  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: BLACK   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) N/A College (1-4 or 5+) N/A   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>UNEMPLOYED   |  | 16b. Kind of Business/Industry   |  |
|  | 17. Father's Name (First, Middle, Last)<br>WILBERT BALDWIN   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>FLORENCE SCOTT   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>LORETTA F. BALDWIN   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>2515 AVALON PL. HYATTSVILLE, MD. 20783   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>HARMONY MEMORIAL PARK  |  | 20c. Location - City or Town, State<br>7/11/97 LANDOVER, MD.  |  | 20d. Date  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |  | 22. Name and Address of Facility<br>AUSTIN ROYSTER FUNERAL HOME<br>3821 14TH STREET N.W., WASH, DC. 20011   |  |  |  |
|  | 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>AIDS<br>Due to (or as a consequence of):<br>Chronic Renal Failure<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death<br>Yrs<br>Yrs.   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |  |
| 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |  |   |  |  |  |
| 29b. Signature and title of certifier<br><i>[Signature]</i> MD   |  | 29c. License number<br>D41978  |  | 29d. Date signed (Month, Day, Year)<br>7-7-97                                |   |  |  |  |
| 30. Name and address of person who completed cause of death (from 23e) (Type, Print)<br>Tawakoli PGH. Cheverly MD 20785  |  |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 23 1997   |  | 32. Registrar's Signature<br><i>[Signature]</i>  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23871

## Certificate of Death

Reg. No.

|   |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
|---|--|---------------------------------------|---|--|--|---|--|--|---|---|--|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|----------------------------------|--|--|--|--|--|--|--|----|--|--|--|--|--|--|--|----------------------------------|--|----|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Elsie S. Whitaker</b>   |                                       |   |  |  |   | 2. Date of Death<br>Month Day Year<br><b>July 21, 1997</b>     |  | 3. Time of Death<br><b>7:20 AM</b>                          |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>  |                                       |   |  |  |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>       |  | 4c. County of Death<br><b>MONTGOMERY</b>                    |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>215-56-8360</b>  |                                       | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>November 1, 1904</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
|   | Usual Residence of Decedent  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Montgomery</b>      |   | 10c. City, Town or Location<br><b>Gaithersburg</b>   |  |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 10e. Street and Number<br><b>19310 Club House Road</b>  |  |                                       |   | 10f. Zip Code<br><b>20879</b>  |  |   |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |  |                                       |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>                                  |  |   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Daniel Belt Smoot</b>   |  |                                       |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Matilda Heil</b>   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Patricia W. Hawfield/Daughter</b>  |  |                                       |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6117 Swansea Street, Bethesda, Maryland 20817</b> |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |                                       |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Montgomery Crematorium, Inc.</b>  |  | Date<br><b>July 22, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Bethesda, Maryland</b>                               |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Michael A. Higgins</i>  |  |                                       |   | 22. Name and Address of Facility<br><b>Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc.<br/>7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501</b> |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| <table border="0"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="8">e. <b>Acute Coronary Insufficiency</b></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td rowspan="2">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="8">b. <b>Atherosclerosis</b></td> </tr> <tr> <td colspan="8">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">c.</td> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td colspan="8">d.</td> <td colspan="2"></td> </tr> </table> |  |                                       |   |  |  |   |  |  |   | Immediate Cause (Final disease or condition resulting in death) | e. <b>Acute Coronary Insufficiency</b> |  |  |  |  |  |  |  | Due to (or as a consequence of): |  |  |  |  |  |  |  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>Atherosclerosis</b> |  |  |  |  |  |  |  | Due to (or as a consequence of): |  |  |  |  |  |  |  | c. |  |  |  |  |  |  |  | Due to (or as a consequence of): |  | d. |  |  |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   | e. <b>Acute Coronary Insufficiency</b>   |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
|   | Due to (or as a consequence of):   |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>Atherosclerosis</b>             |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
|   |  | Due to (or as a consequence of):      |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| c.  |  |                                       |   |  |  |   |  | Due to (or as a consequence of):   |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| d.  |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year) |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |                                       |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Edward Wilson M.D.</i>  |  |                                       |   | 29c. License number<br><b>019322</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>July 21, 1997</b>   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Edward Wilson, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850</b>  |  |                                       |   |  |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>   |  |                                       |   | 32. Registrar's Signature<br><i>Julia Davidson-Rendell</i>   |  |   |  |  |   |   |  |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |  |                           |  |  |  |  |  |  |  |                                  |  |  |  |  |  |  |  |    |  |  |  |  |  |  |  |                                  |  |    |  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

12

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23872

Amended #1,7/25/97/GF, Mont. Co. per FMD

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

PAUL PWU

2. Date of Death

Month

Day

Year

JULY

18 1997

3. Time of Death

0758 A

4a. Facility Name (If not institution, give street and number)

SHADY GROVE ADVENTIST HOSPITAL

4b. City, Town, or Location of Death

ROCKVILLE

4c. County of Death

MONTGOMERY

Funeral  
Director

5. Social Security Number

216-27-8853

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

DECEMBER 24, 1907

9. Birthplace (State or Foreign Country)

CHINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

MONTGOMERY

10c. City, Town or Location

ROCKVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

637 IVY LEAGUE LANE

10f. Zip Code

20850

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.Specify:  
ASIAN15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ASSISTANT MANAGER

16b. Kind of Business/Industry

PETROLEUM

17. Father's Name (First, Middle, Last)

TZU-HSIANG WEI

18. Mother's Name (First, Middle, Maiden Surname)

CHU CHIH

19a. Informant's Name/Relationship (Type, Print)

PATRA WEI PENG/ DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8 ROCK FALLS COURT ROCKVILLE, MARYLAND 20854

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)JULY 20, 1997  
MONTGOMERY CREMATORIUM INC.

Date

20c. Location - City or Town, State

BETHESDA, MARYLAND

21. Signature of Funeral Service Licenses

MO0335

22. Name and Address of Facility

ROBERT A. PUMPHREY FUNERAL HOME/  
ROCKVILLE, INC. 300 WEST MONTGOMERY AVENUE  
ROCKVILLE, MARYLAND 2085023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. MYOCARDIAL INFARCTION

Due to (or as a consequence of):

ACUTE

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE IN DEF

Due to (or as a consequence of):

c. FRACTURED HIP

Due to (or as a consequence of):

5 DAYS

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC PLURAL EFFUSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)

JULY 12 97 1930 P M

28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

FELL

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)

#10

29a. Certifier  
(Check only  
one)1 ☐ Certifying Physician2 ☒ Medical ExaminerTo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D07099

29d. Date signed (Month, Day, Year)

July 18, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

FRANCIS C WAYNE 10215 FERNWOOD RD BETHESDA MD 20817

31. Date filed (Month, Day, Year)

JUL 22 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Bowl  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23873

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Honey A. WATSON

2. Date of Death

Month Day Year

July 21 1997

3. Time of Death

11:30 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

HOLY CROSS HOSPITAL

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

137-18-7908

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

DEC. 30, 1923

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

N.J.

10b. County

CAMDEN

10c. City, Town or Location

HADDONFIELD

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10a. Street and Number

301 WASHINGTON AVE.

10f. Zip Code

08033

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Navar Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

ECONOMIST

16b. Kind of Business/Industry

STATE OF N.J.

17. Father's Name (First, Middle, Last)

ALFRED G. WATSON

18. Mother's Name (First, Middle, Maiden Surname)

THERESA DEMARCO

19a. Informant's Name/Relationship (Type, Print)

S.E. WATSON/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

SAME AS ITEM #10

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHAMBERS CREMATORY

Date

7/24/97

20c. Location - City or Town, State

RIVERDALE, MD.

21. Signature of Funeral Service Licensee

W.W. Chambers

MO0091

22. Name and Address of Facility

CHAMBERS FUNERAL HOMES, P.A., SILVER SPRING, MD. 20910

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. acute myocardial infarction

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

48 hrs

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John T. Tucker

29c. License number

D08546

29d. Date signed (Month, Day, Year)

July 21 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John Tucker

8218 Wisconsin Ave Bethesda

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 24 1997

32. Registrar's Signature

John Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 26a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

19+1



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23874

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |
|--|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Carol</b>  |   | 2. Date of Death<br>Month <b>July</b> Day <b>24</b> Year <b>97</b>  |  | 3. Time of Death<br><b>0303 AM</b>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b>   |   | 4b. City, Town, or Location of Death<br><b>ROCKVILLE</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>579-50-9225</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.   |  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 26, 1939</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>UNKNOWN</b>  |  |  |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>MONTGOMERY</b>  |  | 10c. City, Town or Location<br><b>GAITHERSBURG</b>   |  |
|  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   |   |  |  |  |
|  | 10e. Street and Number<br><b>433 WESTSIDE DR. #102</b>  |   | 10f. Zip Code<br><b>20878</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collage (1-4 or 5+)                      |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NONE</b>   |  |
|  | 16b. Kind of Business/Industry<br><b>NONE</b>   |   | 17. Father's Name (First, Middle, Last)<br><b>UNKNOWN</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>UNKNOWN</b>  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>PATRICIA M. WILCZEK/FRIEND</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>401 HUNGERFORD DR., ROCKVILLE, MD. 20850</b>  |  |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHAMBERS CREMATORY</b>   |  | 20c. Location - City or Town, State<br><b>7/25/97 RIVERDALE, MD.</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>M00091 CHAMBERS FUNERAL HOMES, P.A., RIVERDALE, MD. 20737</b>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>Sepsis</b><br><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Emphysema, Coronary artery disease, Diabetes mellitus</b><br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of):<br><br>Due to (or as a consequence of): |   | Approximate Interval Between Onset and Death<br><b>one week</b>   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Emphysema, Coronary artery disease, Diabetes mellitus</b>   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>July 24, 1997</b>  |   | 28b. Time of Injury<br><b>M</b>  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State) |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |   | 29c. License number<br><b>D42518</b>   |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>JULY 24, 1997</b>  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GUL CHAZIANI, 11119 Rockville Pike, Rockville, MD 20852</b>  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 25 1997</b>  |   | 32. Registrar's Signature<br>  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



97-4064-031

TREVOR  
WALKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23875

|   |  |  |   |  |  |  |   |  |  |
|---|--|--|---|--|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Trevor P. Walker</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>JULY 21 1997</b>  |  | 3. Time of Death<br><b>2:30 P.M.</b>                                    |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>8715 1st AVE</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>SILVER SPRINGS</b>  |  | 4c. County of Death<br><b>MONTGOMERY</b>                                |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>218-19-2373</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>32</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 18, 1964</b>            |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Guyana</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>Montgomery</b>   |  | 10c. City, Town or Location<br><b>Silver Spring</b>                     |  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>4039 Chesterwood Drive</b>   |  | 10f. Zip Code<br><b>20906</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Chef</b>  |  | 16b. Kind of Business/Industry<br><b>Restaurant</b>  |  |   |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Neville A. Walker</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Winifred P. Isaacs</b>  |  | 19. Informant's Name/Relationship (Type, Print)<br><b>Winifred P. Isaacs</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4039 Chesterwood Drive, Silver Spring, MD 20906</b>  |  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metropolitan Crematory</b>  |  | 20c. Location - City or Town, State<br><b>7/23/97 Alexandria, VA</b>    |  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Francis J. Collins Funeral Home, Inc. 500 University Blvd. West Silver Spring, MD 20901</b>  |  |  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Multiple Gunshot Wounds</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> Due to (or as a consequence of):  |  |   |  |  |  |   | Approximate Interval Between Onset and Death   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |  |  |   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)<br><b>27. Manner of Death</b><br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined<br><b>28a. Date of Injury (Month, Day, Year)</b><br><b>7/21/97</b><br><b>28b. Time of Injury</b><br><b>12:45 PM</b><br><b>28c. Injury at Work?</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br><b>28d. Describe how injury occurred</b><br><b>Subject shot</b><br><b>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>hallway of apartment</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b><br><b>8715 First Avenue apartment 312 Silver Spring, Maryland</b> |  |   |  |  |  |   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><br><b>Theodore M. King</b>  |  |   |  |  |  |   | 29c. License number<br><b>O.C.M.E.</b>   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>JULY 22, 1997</b>  |  |   |  |  |  |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M. KING 111 Penn Street, Baltimore, Maryland 21201</b>   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br><b>JUL 24 1997</b>  |  |   |  |  |  |   | 32. Registrar's Signature<br>   |  |
|   | 33. Registrar<br><b>Julia Davidson-Rendell</b>   |  |   |  |  |  |   |  |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23876

## Certificate of Death

Reg. No.

|  |   |   |   |  |   |
|--|---|---|---|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>John Hayden Wathen</b>   |   | 2. Date of Death<br>Month <b>July</b> Day <b>01</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>8:25a.m.</b>   |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>St. Mary's Hospital</b>  |   | 4b. City, Town, or Location of Death<br><b>Leonardtown</b>  |  | 4c. County of Death<br><b>St. Mary's</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>218-54-7166</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>82</b> Yrs.  | If Under 1 Year<br>Months <b>0</b> Days <b>0</b>                             | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>May 7, 1915</b>   |   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  |   |
| To Be Completed by Funeral Director  | Usual Residence of Decedent<br>10a. State <b>Maryland</b> 10b. County <b>St. Mary's</b>   |   | 10c. City, Town or Location<br><b>Bushwood</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 10e. Street and Number<br><b>22089 White Neck Road</b>  |   | 10f. Zip Code<br><b>20618</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br><b>6th Grade</b>   |  |   |
|  | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer</b>   |   | 17. Kind of Business/Industry<br><b>Farm</b>  |  |   |
|  | 18. Father's Name (First, Middle, Last)<br><b>James Ernest Wathen, Sr.</b>  |   | 19. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Etta Pilkerton</b>   |  |   |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Agnes Marie Wathen/Spouse</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>22089 White Neck Road, Bushwood, MD 20618</b> |  |   |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Sacred Heart Cemetery</b>  |  | 20c. Location - City or Town, State<br><b>Bushwood, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br><i>Michael K. Gardiner</i>   |   | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>                   |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Ventricular Tachycardia with out B.P.</b><br>Due to (or as a consequence of):<br><b>b. Cor Pulmonale</b><br>Due to (or as a consequence of):<br><b>c. Pulmonary Hypertension</b><br>Due to (or as a consequence of):<br><b>d.</b> |   | Approximate Interval Between Onset and Death  |  |   |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Insulin Dependent Diabetes</b><br><b>Hypertension.</b>   |   | 23c. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)<br><b>7/2/97</b>  |   | 28b. Time of Injury<br><b>M</b>  |   |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State) |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><i>Dr. Michael S. Szkotniki</i>  |   | 29c. License number<br><b>D31952</b>   |   |
| 29d. Date signed (Month, Day, Year)<br><b>7/2/97</b>   |   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Dr. Michael S. Szkotniki California, MD. 20619</b>   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>JUL -2 1997</b>  |   | 32. Registrar's Signature<br><i>John Davidson</i>   |   |  |   |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23877

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RALPH ERWIN WYRICK

2. Date of Death

Month Day Year  
July 6 1997

3. Time of Death

12:01 AM

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary

Funeral  
Director

5. Social Security Number

577-66-5930

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

48 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Feb 3, 1949

9. Birthplace (State or Foreign Country)

Washington, D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

St. Mary

10c. City, Town or Location

Mechanicville

10d. Inside City Limits

☐ Yes ☒ No

10e. Street and Number

26788 North Sandgates Rd.

10f. Zip Code

20659

10g. Citizen of What Country?

USA

11. Marital Status

☐ Never Married ☐ Married  
☐ Widowed ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
☐ Yes ☐ No  
If Yes, Give  
Year or Dates: 1967-197313. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)☐ Yes ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Allied Security Inc.

17. Father's Name (First, Middle, Last)

Gleason Garnette Wyrick

18. Mother's Name (First, Middle, Maiden Surname)

Minnie Ruth Robinette

19a. Informant's Name/Relationship (Type, Print)

Ruth Wyrick/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26788 North Sandgates Rd., Mechanicville, MD 20659

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State  
☐ Donation ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Charles Memorial Gardens

Date

7/9/97

20c. Location - City or Town, State

Leonardtown, MD

21. Signature of Funeral Service Licensee

Michael L. Gardiner

22. Name and Address of Facility

Mattingley-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, MD 2065023a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. Probable Myocardial Infarction

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☐ No ☐ Probably ☒ Unknown24a. Was an autopsy  
performed?☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?☐ Yes ☒ No25. Was case referred to medical  
examiner?☒ Yes ☐ No

26. Place of Death (Check only one)

Hospital: ☐ Inpatient ☐ ER/Outpatient ☒ DOAOther: ☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural ☐ Pending  
investigation  
☐ Accident ☐ Could not be  
determined  
☐ Suicide ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
☐ Yes ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

William Boyd, III

29c. License number

D14285

29d. Date signed (Month, Day, Year)

July 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. William Boyd, III

Leonardtown, MD 20650

31. Date filed (Month, Day, Year)

JUL - 8 1997

32. Registrar's Signature

John D. ...

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23878

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Elwood Wathen, Sr.

2. Date of Death

Month Day Year  
July 14, 1997

3. Time of Death

5:00a.m.

4a. Facility Name (If not Institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

Funeral  
Director

5. Social Security Number

214-18-8576

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sep 21, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Avenue

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23159 Colton Point Road

10f. Zip Code

20609

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
7th Grade

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Security Guard

16b. Kind of Business/Industry

Electric Company

17. Father's Name (First, Middle, Last)

John Briscoe Wathen

18. Mother's Name (First, Middle, Maiden Surname)

Catherine Gwynette Quade

19a. Informant's Name/Relationship (Type, Print)

Charles David Wathen/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26909 Mechanicsville Rd., Mechanicsville, MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Sacred Heart Cemetery

Date

7/17/97

20c. Location - City or Town, State

Bushwood, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Mattering-Gardiner Funeral Home, P.A.  
P.O. Box 270, Leonardtown, Maryland 20650

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Hypoxemia

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 hr

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Chronic obstructive pulmonary Disease 10 yr.

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

s/p cerebrovascular accident (cerebral hemorrhage)

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D01380

29d. Date signed (Month, Day, Year)

7-14-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. John F. Fenwick Leonardtown, MD. 20650

31. Date filed (Month, Day, Year)

JUL 15 1997

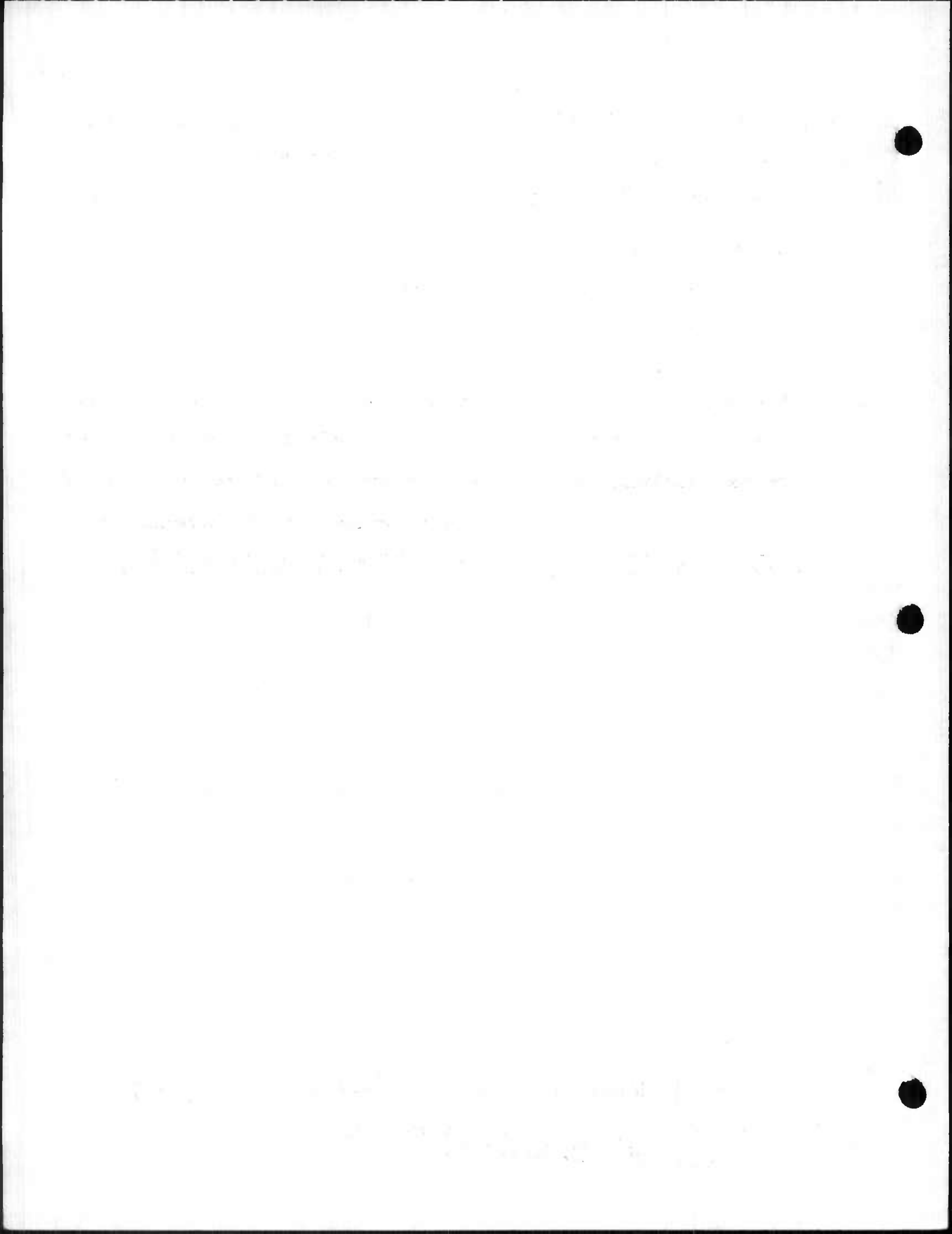
32. Registrar's Signature

State  
RegistrarBaltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 410-326-7222.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

NAME: JOHN ELWOOD WATHEN SR

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23879

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Bernard Dent Wilson, Sr.

2. Date of Death

Month July Day 17, Year 1997

3. Time of Death

10:28AM

4a. Facility Name (If not Institution, give street and number)

Physicians Memorial Hospital

4b. City, Town, or Location of Death

La Plata

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

214-30-4756

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month May Day 30, Year 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

St. Mary's

10c. City, Town or Location

Mechanicsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

26308 Mechanicsville Road

10f. Zip Code

20659

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Farmer

16b. Kind of Business/Industry

Agriculture

17. Father's Name (First, Middle, Last)

William Dent Wilson

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Neale

19a. Informant's Name/Relationship (Type, Print)

Rachel B. Wilson, Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

26308 Mechanicsville Road, Mechanicsville, MD 20659

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Queen of Peace Cemetery

Date

7/21/97

20c. Location - City or Town, State

Helen, Maryland

21. Signature of Funeral Service Licensee

Michael K. Blankenship

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.

22955 Hollywood Road, Leonardtown, MD 20650

Approximate  
Interval Between  
Onset and Death

Days.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line.

Immediate Cause (Final disease or condition resulting in death)

a. Overwhelming Sepsis  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury et

Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D-46419

29d. Date signed (Month, Day, Year)

7/17/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charlene Letchford, MD 700 Old Line Center Suite 100 Waldorf, Maryland 20602

State  
Registrar

31. Date filed (Month, Day, Year)

JUL 21 1997

32. Registrar's Signature

Julia Davidson Randall

Bernard Wilson

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Bernard Wilson

87089 12

[Faint, mostly illegible text throughout the page, appearing to be a form or document with multiple sections and lines of text.]

[Faint signature or stamp visible in the lower right quadrant of the page.]

[Faint text at the bottom of the page, possibly a footer or date.]



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23880

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Wayne Atlee Wise, Sr.

2. Date of Death

Month July Day 24 Year 1997

3. Time of Death

6:57 AM.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

St. Mary's Hospital

4b. City, Town, or Location of Death

Leonardtown

4c. County of Death

St. Mary's

5. Social Security Number

579-03-8428

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
July 30, 1919

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State Maryland  
10b. County St. Mary's

10c. City, Town or Location Ridge

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

49716 Airedale Road

10f. Zip Code

20680

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: WW 213. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contractor/Builder

16b. Kind of Business/Industry

Construction

17. Father's Name (First, Middle, Last)

William H. Wise, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Ethel Symonds

19a. Informant's Name/Relationship (Type, Print)

Richard A. Wise, Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

45885 Stoney Court, Great Mills, Maryland 20634

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metropolitan Crematory

Date

7-24-1997

20c. Location - City or Town, State

Alexandria, Virginia

21. Signature of Funeral Director/Licensee

Michael K. Blankenship, M00852

22. Name and Address of Facility

Brinsfield Funeral Home, P.A.  
22955 Hollywood Road, Leonardtown, Maryland 20650-027923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

Aspiration Pneumonia

Due to (or as a consequence of):

3-5 days

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Recurrent Cerebrovascular Accidents

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus, Hypertension

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner as stated.

29b. Signature and title of certifier

29c. License number

D19917

29d. Date signed (Month, Day, Year)

7/24/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAMES C. BOYD M.D. ST. MARY'S MEDICAL ASSOC. LEONARDTOWN:MD. 20650

31. Date filed (Month, Day, Year)

JUL 25 1997

32. Registrar's Signature

John Davidson Randall

State  
RegistrarBaltimore, Maryland 21215-0020  
Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit  
permit.

WAYNE WISE

Division of Vital Records, P.O. Box 68760,





B.K.S

RICHARD WILLOUGHBY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23881

Item: 23a part I per MEO G-751 9/19/97 dh  
Items: 23a part I, 27, 28a-f per MEO G-750 8/11/97 dh

Certificate of Death

Reg. No.

|  |   |  |  |                               |  |  |  |  |
|--|---|--|--|-------------------------------|--|--|--|--|
| Physician<br>/Medical<br>Examiner                | 1. Decedent's Name (First, Middle, Last)<br>RICHARD WAYNE WILLOUGHBY JR.  |  |  |                               | 2. Date of Death<br>Month Day Year<br>JULY 10, 1997  |  | 3. Time of Death<br>0810AM   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>MARYLAND STATE HOUSE OF CORRECTION  |  |  |                               | 4b. City, Town, or Location of Death<br>Jessup   |  | 4c. County of Death<br>ANNE ARUNDEL  |  |
| Funeral<br>Director                              | 5. Social Security Number<br>219-70-8181  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F                     |                               | 7. Age (In yrs. last birthday)<br>37 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>Feb. 13, 1960   |  |
|  | 10a. State<br>MD.   |  | 10b. County<br>Caroline  |                               | 10c. City, Town or Location<br>Federalsburg  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Funeral Director              | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  |  |                               | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12 1  |  |  |                               | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Musician  |  | 16b. Kind of Business/Industry<br>Musician   |  |
|  | 17. Father's Name (First, Middle, Last)<br>Richard W. Willoughby Sr.  |  |  |                               | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anita L. Hitchens   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br>Anita L. Willoughby/Mother  |  |  |                               | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>616 Old Denton Rd. Federalsburg, MD. 21632  |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Hillcrest Cemetery   |                               | 20c. Location - City or Town, State<br>7/14/97 Federalsburg, MD.   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |  |                               | 22. Name and Address of Facility<br>Williamson Funeral Home, Federalsburg, MD.   |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. BLUNT FORCE INJURIES TO THE ABDOMEN<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |                               |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |                               |  |  |  |  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |                               |  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |                               |  |  |  |  |
| Physician<br>/Medical<br>Examiner                | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |                               | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) JAIL |  |  |  |
|  | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)<br>unknown  |                               | 28b. Time of Injury<br>unknown M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
|  | 28d. Describe how injury occurred<br>subject beaten in jail   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>jail |                               | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>Maryland House of Corrections, Jessup, Md  |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |                               |  |  |  |  |
| State<br>Registrar                               | 29b. Signature and title of certifier<br>   |  |  |                               | 29c. License number<br>O.C.M.E   |  | 29d. Date signed (Month, Day, Year)<br>JULY 11, 1997   |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>J. ARON LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201  |  |  |                               |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>JUL 15 1997 |   |  |  | 32. Registrar's Signature<br> |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23882

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Floyd Ward

2. Date of Death

Month Day Year

July 23 1997

3. Time of Death

3:30 a.m.

4a. Facility Name (If not institution, give street and number)

Deer's Head Center

4b. City, Town, or Location of Death

Salisbury

4c. County of Death

Wicomico

Funeral  
Director

5. Social Security Number

094-01-9967

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

88 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

JULY 13, 1909

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

WICOMICO

10c. City, Town or Location

SALISBURY

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

351 DEER'S HEAD HOSPITAL ROAD

10f. Zip Code

21802

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No 1943-

If Yes, Give Year or Dates: 1945

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

LABORER

16b. Kind of Business/Industry

GRAIN MILL

17. Father's Name (First, Middle, Last)

UNKNOWN

18. Mother's Name (First, Middle, Maiden Surname)

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

SANDRA REYNOLDS/SOCIAL WORKER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P. O. BOX 2018, SALISBURY, MARYLAND 21802

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CAMBRIDGE CREMATORY

Date

7/24/97

20c. Location - City or Town, State

CAMBRIDGE, MARYLAND

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

ZELLER FUNERAL HOME, P. O. BOX 207,

106 MAIN STREET, EAST NEW MARKET, MD 21631

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Congestive Heart Failure

Due to (or as a consequence of):

4 Days

b. Renal Failure

Due to (or as a consequence of):

5 Years

c. Anemia

Due to (or as a consequence of):

5 Years

d. Hypertensive Arteriosclerotic Cardiovascular Disease

10 Years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

D16003

29d. Date signed (Month, Day, Year)

7/23/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

I. J. Hwang, M.D., 351 DEER'S HEAD HOSPITAL ROAD, SALISBURY, MD 21802

31. Date filed (Month, Day, Year)

JUL 28 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23883

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |   |  |  |
|--|--|--|---|--|--|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Martin Yules</b>  |  |   |  | 2. Date of Death<br>Month <b>July</b> Day <b>13</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>7:35PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>10636 MONTROSE AVE., APT.#2</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BETHESDA</b>  |   | 4c. County of Death<br><b>MONTGOMERY</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>070-18-0771</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>72</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 30, 1924</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>NY</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>MONTGOMERY</b>   |   | 10c. City, Town or Location<br><b>GERMANTOWN</b>   |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>10 FOXWOOD CT.</b>   |  | 10f. Zip Code<br><b>20876</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>MUSICIAN</b>  |  | 16b. Kind of Business/Industry<br><b>ENTERTAINMENT</b>   |   |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>LOUIS YULES</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOTTIE HEIN</b>  |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>CHARLOTTE YULES / WIFE</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>10 FOXWOOD CT., GERMANTOWN, MD 20876</b>   |   |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>JUDEAN MEMORIAL GARDENS</b>  |  | Date<br><b>7/15/97</b>   |   | 20c. Location - City or Town, State<br><b>OLNEY, MD</b>  |  |
|  | 21. Signature of Funeral Service Licensee<br><br><b>DANIEL SIMONS</b>  |  |   |  | 22. Name and Address of Facility<br><b>EDWARD SAGEL FUNERAL DIRECTION, INC.<br/>1091 ROCKVILLE PIKE, ROCKVILLE, MD 20852</b>   |   |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic adenocarcinoma of unknown primary</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  | Approximate Interval Between Onset and Death<br><b>5 months</b>  |   |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |  |   |  |  |
|  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |  |   |  |  |
| State Registrar  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  | 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D43083</b>   |  |
|  | 29d. Date signed (Month, Day, Year)<br><b>July 14, 1997</b>  |  |   |  |  |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>9707 Medical Center Dr, #300 Rockville MD 20850</b>   |  |   |  |  |   |  |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>              |  |  |   | 32. Registrar's Signature<br> |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

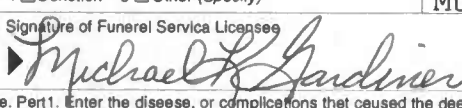
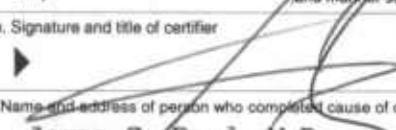



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23884

Amended #5 7-29-97 BLT St. Mary's Certificate of Death

Reg. No.

|  |   |   |   |   |  |
|--|---|---|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Chester Young</b>  |   | 2. Date of Death<br>Month <b>July</b> Day <b>19</b> Year <b>1997</b>  |   | 3. Time of Death<br><b>5:50 P.M.</b>   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Bayside Nursing Center</b>   |   | 4b. City, Town, or Location of Death<br><b>Lexington Park</b>   |   | 4c. County of Death<br><b>St. Mary's</b>   |
| Funeral<br>Director  | 5. Social Security Number<br><b>233-36-4274</b>   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>68</b> Yrs.  | If Under 1 Year<br>Months Days                        | If Under 24 Hrs.<br>Hours Min.   |
|  | Usual Residence of Decedent<br><b>223-36-4274</b>   |   | 8. Date of Birth (Month, Day, Year)<br><b>Jan 28, 1929</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Virginia</b>  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>St. Mary's</b>  | 10c. City, Town or Location<br><b>St. Inigoes</b>   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 10e. Street and Number<br><b>P.O. Box 123</b>   |   | 10f. Zip Code<br><b>20684</b>   |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>6th Grade</b> College (1-4 or 5+)               |   |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>   |   | 16b. Kind of Business/Industry<br><b>State Government</b>   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Ernest Young</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Frances Ross</b>   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Janie E. Young/Spouse</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>P.O. Box 123, St. Inigoes, MD 20684</b>       |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Zion Un. Methodist Cem</b>                                       |   | 20c. Location - City or Town, State<br><b>St. Inigoes, MD</b>  |
|  | 21. Signature of Funeral Service Licensee<br>   |   | 22. Name and Address of Facility<br><b>Mattingley-Gardiner Funeral Home, P.A.<br/>P.O. Box 270, Leonardtown, Maryland 20650</b>                   |   |  |
|  | 23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                           |   |   |   |  |
| Physician<br>/Medical<br>Examiner  | Immediate Cause (Final disease or condition resulting in death)<br><b>Hepatic encephalopathy</b><br>Due to (or as a consequence of):  |   | Approximate Interval Between Onset and Death<br><b>2-3 years</b>  |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Cirrhosis</b><br>Due to (or as a consequence of):                    |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
|  | Due to (or as a consequence of):  |   |   |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |   |   |   |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |   |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                       |  |
| 28c. Injury et Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28d. Describe how injury occurred   |   |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |   |   |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br><b>D19917</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>7/21/97</b> |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>James C. Boyd, M.D. California, MD 20619</b>  |   |   |   |   |  |
| 31. Date filed (Month, Day, Year)<br><b>JUL 22 1997</b>  |   | 32. Registrar's Signature<br>  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23885

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY CATHERINE ZANDIN

2. Date of Death

Month Day Year  
JULY 21, 1997

3. Time of Death

8:25 AM

4a. Facility Name (If not institution, give street and number)

505 DERRYDOWN LANE

4b. City, Town, or Location of Death

SILVER SPRING

4c. County of Death

MONTGOMERY

5. Social Security Number

578-46-7016

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

94 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 14, 1902

9. Birthplace (State or Foreign Country)

Pennsylvania

Usual Residence of Decedent

10a. State

Maryland

10b. County

Montgomery

10c. City, Town or Location

Silver Spring

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

505 Derrydown Lane

10f. Zip Code

20904

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Receptionist

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Patrick J. Boland

18. Mother's Name (First, Middle, Maiden Surname)

Mary M. McCaffrey

19a. Informant's Name/Relationship (Type, Print)

Lucy Boland (Niece)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

9707 Kings Crown Court #2, Fairfax, Virginia 22031

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Arlington National Cemetery 7/22/97 Arlington, Virginia

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

DeVol Funeral Home

10 East Deer Park Dr., Gaithersburg, MD 20877

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. RESPIRATORY FAILURE

MINUTES

Due to (or as a consequence of):

b. FLUID &amp; ELECTROLYTE IMBALANCE

2 WKS

Due to (or as a consequence of):

c. DEBILITY FROM SPINAL STENOSIS

YEARS

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

OSTEOPOROSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending

Investigation

6 ☐ Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of Certifier

29c. License number

DO 2338

29d. Date signed (Month, Day, Year)

July 21, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Richard P. Delaney, M.D., 9801 Georgia Avenue, #109 Silver Spring, MD 20902

31. Date filed (Month, Day, Year)

JUL 23 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

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Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



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State of Maryland / Department of Health and Mental Hygiene

97 23886

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hugh Muir Arnold Sr.

2. Date of Death

August 5 1997

3. Time of Death

3:27 pm

4a. Facility Name (If not Institution, give street and number)

Franklin Square Hospital Center

4b. City, Town, or Location of Death

Rossville

4c. County of Death

Baltimore Co.

Funeral  
Director

5. Social Security Number

214-24-0274

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

69 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 23, 1928

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore Co.

10c. City, Town or Location

Carney

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3319 Upton Road

10f. Zip Code

21234

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

Claims Examiner

16b. Kind of Business/Industry

U.S. Government

17. Father's Name (First, Middle, Last)

James W. Arnold

18. Mother's Name (First, Middle, Maiden Surname)

Margaret Reed

19a. Informant's Name/Relationship (Type, Print)

Mr. Hugh Arnold, Jr./ Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4802 Holder Avenue Baltimore, Maryland 21214

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Hilltop Service Corporation

Date

8/8/97

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

► Brian A. Willem

5305 Harford Road Baltimore, Maryland 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARDIO MYOPATHY

YRS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. CORONARY ARTERY DISEASE

YRS

Due to (or as a consequence of):

c. GENERALIZED ASCVD

YRS

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC OBSTRUCTIVE PULMONARY DISEASE

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient3 ☒ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

► Vincent A. DiPietro

29c. License number

D28812

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Vincent A. DiPietro 7801 York Road Ste. 102 Towson, Md. 21204

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Registrar or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The funeral director, after this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23887

## Certificate of Death

Reg. No.

|   |  |  |   |                           |   |  |  |  |
|---|--|--|---|---------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>MARSHALL HARRISON ALLEN</b>   |  |   |                           | 2. Date of Death<br>Month <b>Aug</b> Day <b>3</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>10 35 A</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>3600 LABYRINTH ROAD</b>   |  |   |                           | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>WIA</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-14-4069</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  | If Under 1 Year<br>Months | If Under 24 Hrs.<br>Hours   | 8. Date of Birth (Month, Day, Year)<br><b>Sept 3, 1923</b> | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>                      |  |
|   | Usual Residence of Decedent  |  |   |                           | 10e. State<br><b>Maryland</b>   |  | 10b. County<br><b>WIA</b>  |  |
| To Be Completed by Funeral Director           | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |   |                           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
|   | 10e. Street and Number<br><b>3600 LABYRINTH ROAD</b>   |  |   |                           | 10f. Zip Code<br><b>21215</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                                      |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b> |                           | 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>black</b>          |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th grade</b>  |  | College (14 or 5+)  |                           | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Iron Worker</b>   |  | 16b. Kind of Business/Industry<br><b>MD SHIPBUILDERS and Drydock</b>             |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>JOHN ALLEN, SR.</b>  |  |   |                           | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>BLANCHE CHASE</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type/Print)<br><b>Lillian Allen / wife</b>   |  |   |                           | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3600 LABYRINTH APT F11 BALTIMORE, MD 21215</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Veterans Cem.</b>  |                           | Date<br><b>8/8/97</b>   |  | 20c. Location - City or Town, State<br><b>Owings Mills, MD</b>                   |  |
|   | 21. Signature of Funeral Service Licensee<br><b>[Signature]</b>  |  |   |                           | 22. Name and Address of Facility<br><b>CHATMAN - HARRIS Funeral Home<br/>5240 REISTERSTOWN ROAD<br/>BALTIMORE, Maryland 21215</b>   |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LARYNGEAL CANCER</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |                           |   |  |  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |                           |   |  |  |  |
| Physician<br>/Medical<br>Examiner             | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |                           | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |
|   |  |  |   |                           | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                           | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |                           | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 28d. Describe how injury occurred  |  |   |                           | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  |
| State<br>Registrar                            | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |                           | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D29071</b>   |  |
|   | 29d. Date signed (Month, Day, Year)<br><b>8-4-97</b>   |  |   |                           | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>R. KRISHNAN, MD 821, N. EUTAW ST #305 BALTIMORE MD 21201</b>   |  |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |   |                           | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |  |



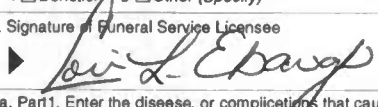
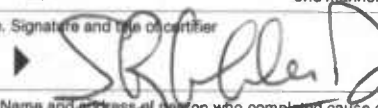
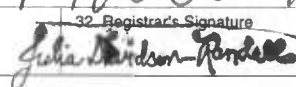
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23888

## Certificate of Death

Reg. No.

|  |   |   |   |  |  |  |  |  |  |
|--|---|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Paul F. Armstrong                                 |   |   |  | 2. Date of Death<br>Month Day Year<br>AUGUST 5, 1997 |  | 3. Time of Death<br>3:36 AM  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br>NORTH ARUNDEL HOSPITAL ASSN |   |   |  | 4b. City, Town, or Location of Death<br>GLEN BURNIE  |  | 4c. County of Death<br>ANNE ARUNDEL  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>216-16-5623  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br>73 Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                       | 8. Date of Birth (Month, Day, Year)<br>Jan. 24, 1924   |  | 9. Birthplace (State or Foreign Country)<br>Ohio |  |
|  | Usual Residence of Decedent   |   |   |  |  |  |  |  |  |
| 10a. State<br>Maryland   |   | 10b. County<br>Anne Arundel   |   | 10c. City, Town or Location<br>Glen Burnie   |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br>115 Main Ave. S.W.   |   |   |   | 10f. Zip Code<br>21061   |  | 10g. Citizen of What Country?<br>United States   |  |  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: WW II   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) College (1-4 or 5+)<br>12   |   |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Truck Driver  |  |  | 16b. Kind of Business/Industry<br>Transportation   |  |  |
| 17. Father's Name (First, Middle, Last)<br>Edward Chandler Armstrong   |   |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Alice Hitch   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>Dorothy H. Armstrong/Wife  |   |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>115 Main Ave. S.W. Glen Burnie, MD 21061  |  |  |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Crownsville Vet. Cemetery   |   | Date<br>Aug. 8, 1997   |  | 20c. Location - City or Town, State<br>Crownsville, MD   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |   | 22. Name and Address of Facility<br>Kirkley-Ruddick Funeral Home<br>421 Crain Hwy S.E. Glen Burnie, MD 21061   |  |  |  |  |  |
| 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. Myocardial rupture<br>Due to (or as a consequence of):<br>b. Myocardial infarction<br>Due to (or as a consequence of):<br>c. Arteriosclerotic heart disease<br>Due to (or as a consequence of):<br>d.<br><br>Approximate Interval Between Onset and Death<br>minutes<br>3 days<br>6 mos |   |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|  |   |   |   |  |  | 24e. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |  |  |
|  |   |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |   | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred                |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29e. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   | 29c. License number<br>208387   |   | 29d. Date signed (Month, Day, Year)<br>8-6-97  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>SR. Gehlert 1600 Ocean Hwy Glen Burnie Md 21061  |   |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>AUG 07 1997   |   | 32. Registrar's Signature<br>  |   |  |  |  |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b-f show any injury or other traumatic event, the Medical Examiner must be notified at 6058.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23889

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Rose F. Albione</b>   |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>4</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:30 pm</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Perring Pkwy. Center-Genesis Eldercare</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Parkville</b>   |  | 4c. County of Death<br><b>Baltimore Co.</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-12-1720</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>78</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 11, 1918</b>                          |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore City</b>                                 |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>2800 Berwick Avenue</b>  |  | 10f. Zip Code<br><b>21234</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                                |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>              |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Aniceto Falconi</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Scandaliato</b>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>John P. Albione</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2800 Berwick Avenue Baltimore, Maryland 21234</b>  |  |  |  |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) <b>Entombment</b>  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lorraine Park Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Baltimore Maryland</b>   |  | 20d. Date<br><b>8/8/97</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Milton J. Knight Jr</b>  |  |   |  | 22. Name and Address of Facility<br><b>Leonard J. Ruck Funeral Home, Inc.<br/>5305 Harford Road Baltimore, Maryland 21214</b>  |  |  |  |
|  | 23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>Lymphoma</b><br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>Perforated peptic ulcer</b> |  |   |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  |  |  |  |  |
|  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |  |   |  |  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how injury occurred   |  |  |  |  |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br><b>Francis L. Wiegmann, Jr. MD</b>  |  | 29c. License number<br><b>D25569</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>08/05/97</b>   |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Francis L. Wiegmann, Jr. MD / 8406 Harford Rd. / Baltimore, Md. 21234</b>   |  |   |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the funeral-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23890

## Certificate of Death

Reg. No.

|  |   |  |   |  |   |   |  |   |                                   |  |
|--|---|--|---|--|---|---|--|---|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES EDWIN BRADLEY, Jr.</b>   |  |   |  | 2. Date of Death<br>Month Day Year<br><b>August 2, 1997</b>   |   | 3. Time of Death<br><b>9:30 PM</b>   |   |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>VA MHCS Fort Howard Division</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>FORT HOWARD</b>  |   | 4c. County of Death<br><b>BALTIMORE</b>  |   |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>274-09-4392</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>83</b> Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Jan. 14, 1914</b>  | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>  |                                   |  |
|  | Usual Residence of Decedent   |  |   |  |   |   |  |   |                                   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                   |  |
|  | 10e. Street and Number<br><b>1214 Sugerwood Cr. Apt. G</b>  |  |   |  | 10f. Zip Code<br><b>21221</b>   |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |                                   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WW-II</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b><br>College (1-4 or 5+) <b>College</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Man</b>   |  |   | 16b. Kind of Business/Industry<br><b>Sales</b>  |  |   |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>James Edwin Bradley, Sr.</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Gambrills</b>   |   |  |   |                                   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. James E. Bradley, III/son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>19 Ruxview Ct. #101 Towson, Md. 21204</b>   |   |  |   |                                   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Memorial</b>  |  | Data<br><b>8/5/97</b>   |   | 20c. Location - City or Town, State<br><b>Timonium, Md.</b>  |   |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>   |   |  |   |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Recurrent Aspiration Pneumonia</b><br>Dua to (or as a consequence of):<br><br>b. <b>Dementia Secondary Chronic Alcoholism</b><br>Dua to (or as a consequence of):<br><br>c. <b>Protein Malnutrition</b><br>Dua to (or as a consequence of):<br><br>d.<br><br>Approximate Interval Between Onset and Death<br><b>10 Yrs.</b><br><b>15 Yrs.</b><br><b>10 Yrs.</b> |  |   |  |   |   |  |   |                                   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |                                   |  |
|  |   |  |   |  |   | 24s. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |                                   |  |
|  |   |  |   |  |   |   |  |   |                                   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |   |  |   |                                   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   | 28d. Describe how injury occurred |  |
|  |   |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                                   |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  | 29c. License number<br><b>D45148</b>  |  |   |   | 29d. Date signed (Month, Day, Year)<br><b>August, 3, 1997</b>  |   |                                   |  |
|  | 29b. Signature and title of certifier<br>  |  |   |  |   |   |  |   |                                   |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DR. RICARDO ORSONO, M.D. 9600 NORTH POINT RD., FT. HOWARD, MD 21052</b>  |  |   |  |   |   |  |   |                                   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  | 32. Registrar's Signature<br>  |  |   |   |  |   |                                   |  |

BRADLEY, JAMES - 4392

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



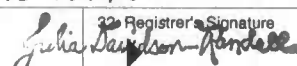
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23891

Reg. No.

|  |   |                          |  |   |  |   |  |  |  |   |  |
|--|---|--------------------------|--|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Willie T. Brown</b>                            |                          |  |   |  |   | 2. Date of Death<br>Month <b>Aug</b> Day <b>5</b> Year <b>1997</b>               |  | 3. Time of Death<br><b>5:00 pm</b>                     |   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Joseph Ritchey House</b> |                          |  |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>                         |  | 4c. County of Death<br><b>NA</b>                       |   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-62-1683</b>   |                          | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>41</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>04-05-56</b>                           |  | 9. Birthplace (State or Foreign Country)<br><b>Md.</b> |   |  |
|  | Usual Residence of Decedent   |                          |  |   |  |   |  |  |  |   |  |
| 10a. State<br><b>Md</b>  |   | 10b. County<br><b>NA</b> |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
| 10e. Street and Number<br><b>1011 Reverdy Road</b>   |   |                          |  | 10f. Zip Code<br><b>21212</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>                               |  |  |  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th Grade</b><br>College (1-4or 5+) <b>NA</b>  |   |                          |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>                           |  |   | 16b. Kind of Business/Industry<br><b>various trades</b>                          |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>Willie Brown</b>   |   |                          |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mattie Stokes</b> |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mattie Dennis</b>   |   |                          |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21239 6101 Loch Raven Blvd. Apt. #615 Balto, Md.</b> |  |   |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Voshell Mem. Gardens</b>  |   |  | Date<br><b>08-08-97</b>   |  | 20c. Location - City or Town, State<br><b>Dundalk, Md.</b>   |  |   |  |
| 21. Signature of Funeral Service Licensee<br>  |   |                          |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>   |  |   |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebral toxoplasmosis</b><br>Due to (or as a consequence of):<br><b>b. Acquired Immune deficiency Disease</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |                          |  |   |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>1 year</b><br><b>4 years</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Pulmonary Aspergillosis</b>   |   |                          |  |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |   |  |
|  |   |                          |  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
|  |   |                          |  |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b> |   |  |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |                          | 28a. Date of Injury (Month, Day, Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how injury occurred                      |   |  |
|  |   |                          | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |                          |  |   |  |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |   |                          | 29c. License number<br><b>17 14 383</b>  |   |  | 29d. Date signed (Month, Day, Year)<br><b>August 6, 1997</b>              |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Harold C Standiford MD Joseph Ritchey Hospice Baltimore</b>   |   |                          |  |   |  |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |   |                          | 32. Registrar's Signature<br>   |   |  |   |  |  |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



MARGARET  
BEAVIN

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23892

## Certificate of Death

Reg. No.

|  |   |  |  |  |   |                                |  |   |
|--|---|--|--|--|---|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>Margaret Beavin   |  |  |  | 2. Date of Death<br>Month Day Year<br>JULY 11 1997  |                                | 3. Time of Death<br>4:35 P.M.  |   |
|  | 4a. Facility Name (If not Institution, give street and number)<br>1431 MOSANDER WAY   |  |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |                                | 4c. County of Death<br>Baltimore City  |   |
| Funeral<br>Director  | 5. Social Security Number<br>UNKNOWN  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br>*85 Yrs. | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br>Sept 8, 1911  | 9. Birthplace (State or Foreign Country)<br>unknown |
|  | Usual Residence of Decedent   |  |  |  |   |                                |  |   |
| To Be Completed by Funeral Director                                  | 10a. State<br>Maryland  |  | 10b. County<br>Baltimore City  |  | 10c. City, Town or Location<br>Baltimore  |                                | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |
|  | 10e. Street and Number<br>1431 Mosander Way   |  |  |  | 10f. Zip Code<br>21224  |                                | 10g. Citizen of What Country?<br>Baltimore City  |   |
|  | 11. Marital Status unknown<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: White                                   |   |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) unknown<br>College (1-4 or 5+) unknown   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>unknown                       |  | 16b. Kind of Business/Industry<br>unknown   |                                |  |   |
|  | 17. Father's Name (First, Middle, Last)<br>unknown  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>unknown  |                                |  |   |
| Physician<br>/Medical<br>Examiner                                    | 19a. Informant's Name/Relationship (Type, Print)<br>unknown   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>unknown  |                                |  |   |
|  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) in state  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Date  |                                | 20c. Location - City or Town, State  |   |
|  | 21. Signature of Funeral Service Licensee<br>Ronald S. Wade, Director   |  |  |  | 22. Name and Address of Facility<br>State Anatomy Board, 655 W. Baltimore Street<br>Baltimore, Maryland 21201   |                                |  |   |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>Hypertensive Atherosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>Colon Cancer<br>Due to (or as a consequence of): |  |  |  |   |                                |  |   |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |  |   |                                |  |   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                |  |   |
|  | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |                                |  |   |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br>M  |                                | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No               |   |
|  | 28d. Describe how injury occurred   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                                |  |   |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |   |                                |  |   |
| State<br>Registrar   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |  |  |   |                                |  |   |
|  | 29b. Signature and title of certifier<br>[Signature]  |  |  |  | 29c. License number<br>O.C.M.E.   |                                | 29d. Date signed (Month, Day, Year)<br>JULY 12, 1997   |   |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>JLARON LOFF, MD 111 Penn Street, Baltimore, Maryland 21201  |  |  |  |   |                                |  |   |
| 31. Date filed (Month, Day, Year)<br>AUG 07 1997                     |   |  |  | 32. Registrar's Signature<br>[Signature]   |   |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

If the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
If the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.





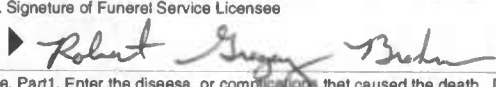
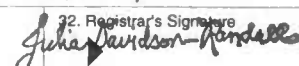
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23893

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |   |  |
|--|--|---|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD G. BRUNSTETTER</b>   |   |   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>02</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:30AM</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5400 VANTAGE POINT ROAD, APT 405</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>  |  | 4c. County of Death<br><b>HOWARD</b>                                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>138-18-5519</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>76</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 22 1921</b>              |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>PA</b>  |   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>HOWARD</b>   |  | 10c. City, Town or Location<br><b>COLUMBIA</b>                          |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>5400 VANTAGE POINT ROAD, APT 405</b>   |  | 10f. Zip Code<br><b>21044</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                          |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |
| To Be Completed by Physician/Medical Examiner  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>5+</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>ENGINEER</b>                      |  | 16b. Kind of Business/Industry<br><b>DEFENSE</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>JESSE BRUNSTETTER</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARIAN nee (KELLOW)</b>  |  |   |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>JEAN BRUNSTETTER</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5400 VANTAGE POINT RD, COLUMBIA MD 21044</b>   |  |   |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CARROLL CREMATORY 08-03-97 HAMSTEAD, MD</b>                          |  | 20c. Location - City or Town, State  |  | 20d. Date   |  |
| To Be Completed by Physician/Medical Examiner  | 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>WITZKE FUNERAL HOMES INC.<br/>5555 TWIN KNOLLS RD, COLUMBIA MD 21045</b>  |  |   |  |
|  | 23a. Part I. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>Immediate Cause (Final disease or condition resulting in death)</p> <p>a. <b>Congestive Cardiomyopathy - end stage</b><br/>Due to (or as a consequence of):</p> <p>b. <b>Renal Insufficiency</b><br/>Due to (or as a consequence of):</p> <p>c. <b>chronic Atrial fibrillation</b><br/>Due to (or as a consequence of):</p> <p>d. <b>Diabetes</b><br/>Due to (or as a consequence of):</p> </div> <div style="width: 35%;"> <p>Approximate interval Between Onset and Death</p> <p>a. <b>yes</b></p> <p>b. <b>yes</b></p> <p>c. <b>yes</b></p> <p>d. <b>yes</b></p> </div> </div> |   |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |
|  |  |   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
|  |  |   |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |
|  |  | 28d. Describe how injury occurred   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)                           |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |   |  |  |  |   |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br><b>D-34868</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 2, 1997</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DICEN 11055 LITTLE PARKWAY COLUMBIA, MD 21044</b>   |  |   |   |  |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |   |   | 32. Registrar's Signature<br> |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



|   |  |  |   |  |  |                                    |  |   |  |
|---|--|--|---|--|--|------------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>HERBERT EMIL BOBERG</b>   |  |   | 2. Date of Death<br>Month <b>AUG.</b> Day <b>3</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>2006 PM</b> |  |   |  |
|   | 4e. Facility Name (If not institution, give street and number)<br><b>2753 WEST NORTH AVENUE</b>  |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-54-6945</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>46</b> Yrs.   |                                    | 8. Date of Birth (Month, Day, Year)<br><b>NOV. 29 1950</b>                                     |   |  |
|   | Usual Residence of Decedent  |  | 9. Birthplace (State or Foreign Country)<br><b>GERMANY</b>  |  | 10. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                    |  |   |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |                                    | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|   | 10e. Street and Number<br><b>2602 GWYNNDALE AVENUE</b>   |  | 10f. Zip Code<br><b>21207</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |                                    |  |   |  |
| To Be Completed by Physician/Medical Examiner | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:                             |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |                                    | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>                        |   |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b><br>College (1-4 or 5+) <b>College (1-4 or 5+)</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DRY WALL MECHANIC</b>   |  | 16b. Kind of Business/Industry<br><b>CONSTRUCTION</b>  |                                    |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>JOSEPH BOBERG</b>  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LYDIA VIET</b>   |  |                                    |  |   |  |
|   | 19e. Informant's Name/Relationship (Type, Print)<br><b>Leslie M. Boberg/ Wife</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2602 Gwynndale Avenue, Baltimore, Maryland 21207</b> |  |                                    |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |  | Date<br><b>8-6-97</b>  |                                    | 20c. Location - City or Town, State<br><b>BALTIMORE, MARYLAND</b>                              |   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  |   | 22. Name and Address of Facility<br><b>WILLIAM C. BROWN COMMUNITY F/H<br/>1206 W. NORTH AVENUE</b>   |  |                                    |  |   |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. NARCOTIC, COCAINE AND ALCOHOL INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |                                    |  | Approximate Interval Between Onset and Death  |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |                                    |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |                                    |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |  |                                    |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>8/3/97</b>   |  | 28b. Time of Injury<br><b>unknown M</b>  |                                    | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>found in house</b>  |  | 28d. Describe how injury occurred<br><b>unknown</b><br>28f. Location (Street and Number or Rural Route Number, City or Town, State) <b>2753 W. North Ave., Baltimore, Md.</b> |  |  |                                    |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |                                    |  | 29b. Signature and title of certifier<br>  |  |
|   | 29c. License number<br><b>O.C.M.E</b>  |  |   |  |  |                                    |  | 29d. Date signed (Month, Day, Year)<br><b>AUG. 4, 1997</b>  |  |
| State Registrar                               | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Davidson-Randall, MD 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |  |  |                                    |  | 31. Date filed (Month, Day, Year)<br><b>AUG 7 1997</b>  |  |
|   | 32. Registrar's Signature<br>   |  |   |  |  |                                    |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





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State of Maryland / Department of Health and Mental Hygiene

97 23895

## Certificate of Death

Reg. No.

|  |   |   |  |  |   |  |  |  |  |
|--|---|---|--|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Henry Arthur Cook</b>                        |   |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>1</b> Year <b>1997</b> |  | 3. Time of Death<br><b>11:35 AM</b>                        |  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>7395 Edsworth Road</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Dundalk</b>                |  | 4c. County of Death<br><b>Baltimore</b>                    |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>232-46-6709</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                      |  | 8. Date of Birth (Month, Day, Year)<br><b>Aug. 2, 1930</b> |  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>West Virginia</b>                            |   | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>                                       |  | 10c. City, Town or Location<br><b>Dundalk</b>              |  |  |
| Usual Residence of Decedent  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>7395 Edsworth Road</b>  |   | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <b>Korean</b><br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>          |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>Unknown</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Production</b>  |  | 16b. Kind of Business/Industry<br><b>Manufacturing</b>   |   |  |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Henry Cook</b>   |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Opal Ferrell</b>   |   |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Frances L. Bowman/Daughter</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7803 Jamesford Road Dundalk, Maryland 21222</b>  |   |  |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Ph. Cem.</b>  |  | 20c. Date<br><b>8/5/97</b>   |   | 20d. Location - City or Town, State<br><b>Elkridge, Maryland</b>                 |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |   |   |  | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |   |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. LUNG CANCER</b><br>Due to (or as a consequence of):<br><br>b. Due to (or as a consequence of):<br><br>c. Due to (or as a consequence of):<br><br>d. Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |   |  |  |   |  |  | Approximate Interval Between Onset and Death<br><b>6 Mos</b>   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |
|  |   |   |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |   |   |  |  |   |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 28. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  | 28d. Describe how Injury occurred  |  |
|  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |   |   |  |  |   |  |  |  |  |
| 29b. Signature and title of certifier<br>   |   |   |  | 29c. License number<br><b>P27730</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>8/4/97</b>                             |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>GARY COHEN, MO 6569 N. CHAMBER ST. BALTIMORE, MD. 21204</b>   |   |   |  |  |   |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |   | 32. Registrar's Signature<br>  |  |  |   |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

10

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23896

|   |  |  |  |  |  |  |   |  |
|---|--|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>EDNA V. CHAMP</b>   |  |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>5th</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>15:00 hrs</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Maryland General Hospital</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore City</b>  |  | 4c. County of Death<br><b>NA</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>579-12-3974</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (in yrs. last birthday)<br><b>81</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>12-31-1915</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Ua</b>  |  | 10e. State<br><b>MD</b>  |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>1100 Pennsylvania Avenue</b>  |  | 10f. Zip Code<br><b>21201</b>   |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A</b>  |  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>NA</b>    |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Domestic</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Private Homes</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Lee Champ</b>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Kula Dade</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Hestie Champ - Son</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1100 Pennsylvania Ave Baltimore</b>           |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>King Memorial Park</b>  |  | 20c. Location - City or Town, State<br><b>8-8-97 Randallstown, MD</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Bladys Wane</b>  |  |  |  | 22. Name and Address of Facility<br><b>March F.H. West 4300 Wabash Avenue Baltimore, MD 21215</b>  |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><br>a. <b>Collapse of Lung</b><br>Due to (or as a consequence of):<br><br>b. <b>Expanding Aortic Aneurysm</b><br>Due to (or as a consequence of):<br><br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br><br>d.<br><br>Approximate Interval Between Onset and Death<br><b>Few days</b><br><b>years</b> |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |
| To Be Completed by Physician/Medical Examiner | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |  |
|   | 29b. Signature and title of certifier<br><b>Wital Dave</b>   |  |  |  | 29c. License number<br><b>89290</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>8/5/97</b>  |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Wital Dave, M.D. 40 Maryland General Hospital</b>   |  |  |  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>Davidson-Randall</b>   |  |  |  |  |  |   |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Items: 10e, 19b per FH G-750 8/15/97 dh  
 ITEM: 16a per FH G-750 8-7-97 eoh

State of Maryland / Department of Health and Mental Hygiene

97 23897

## Certificate of Death

Reg. No.

|  |  |  |   |                                |  |
|--|--|--|---|--------------------------------|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>ROBERT CAMPBELL</b>   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>4</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>4:27 PM</b>   |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>Saint Joseph Medical Center</b>   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>   |                                | 4c. County of Death<br><b>Baltimore</b>  |
| Funeral<br>Director  | 5. Social Security Number<br><b>040-40-9205</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>49</b> Yrs.  | If Under 1 Year<br>Months Days | If Under 24 Hrs.<br>Hours Min.   |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 22, 1947</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>Manchester, N.H.</b>   |                                |  |
| To Be Completed by Funeral Director                                  | Usual Residence of Decedent  |  | 10e. State<br><b>Maryland</b>   |                                | 10b. County<br><b>Baltimore Co.</b>  |
|  | 10c. City, Town or Location<br><b>Stevenson</b>  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                |  |
|  | 10e. Street and Number<br><b>2007 Greenspring Valley Road</b>  |  | 10f. Zip Code<br><b>21153</b>   |                                | 10g. Citizen of What Country?<br><b>United States</b>  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                                | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>04</b>              |                                |  |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>EMPLOYED Self-Employed/Owner</b>   |  | 16b. Kind of Business/Industry<br><b>Advertising</b>  |                                |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George Rosbrook Campbell</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jane Ramsdell</b>   |                                |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br><b>Nancy C. Gallons (Sister)</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>311 Ashbourne Road Claymont, Delaware 19703</b> |                                |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Corp.</b>  |                                | 20c. Location - City or Town, State<br><b>8/06/97 Towson, Maryland</b>   |
|  | 21. Signature of Funeral Service Licensee<br><b>Jeffrey L. Gair</b>  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                       |                                |  |
| Physician<br>/Medical<br>Examiner                                    | 23e. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ADULT RESPIRATORY DISTRESS SYNDROME</b>  |  |   |                                | Approximate Interval Between Onset and Death<br><b>72 HOURS</b>  |
|  | 23e. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>STATUS POST CORONARY ARTERY BYPASS SURGERY</b>   |  |   |                                |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |                                |  |
|  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |                                |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |                                |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |                                | 28b. Time of Injury<br><b>M</b>  |
|  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred   |                                |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |                                |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |   |                                |  |
|  | 29b. Signature and title of certifier<br><b>R. Stewart Finney M.D.</b>   |  | 29c. License number<br><b>D 38655</b>   |                                | 29d. Date signed (Month, Day, Year)<br><b>8/5/97</b>   |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>R. STEWART FINNEY M.D., 7505 OSLER DR. TOWSON, MARYLAND 21204 MARYLAND</b>  |  |   |                                |  |
| State Registrar  | 31. Date (Month, Day, Year)<br><b>AUG 07 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson</b>  |                                |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

25



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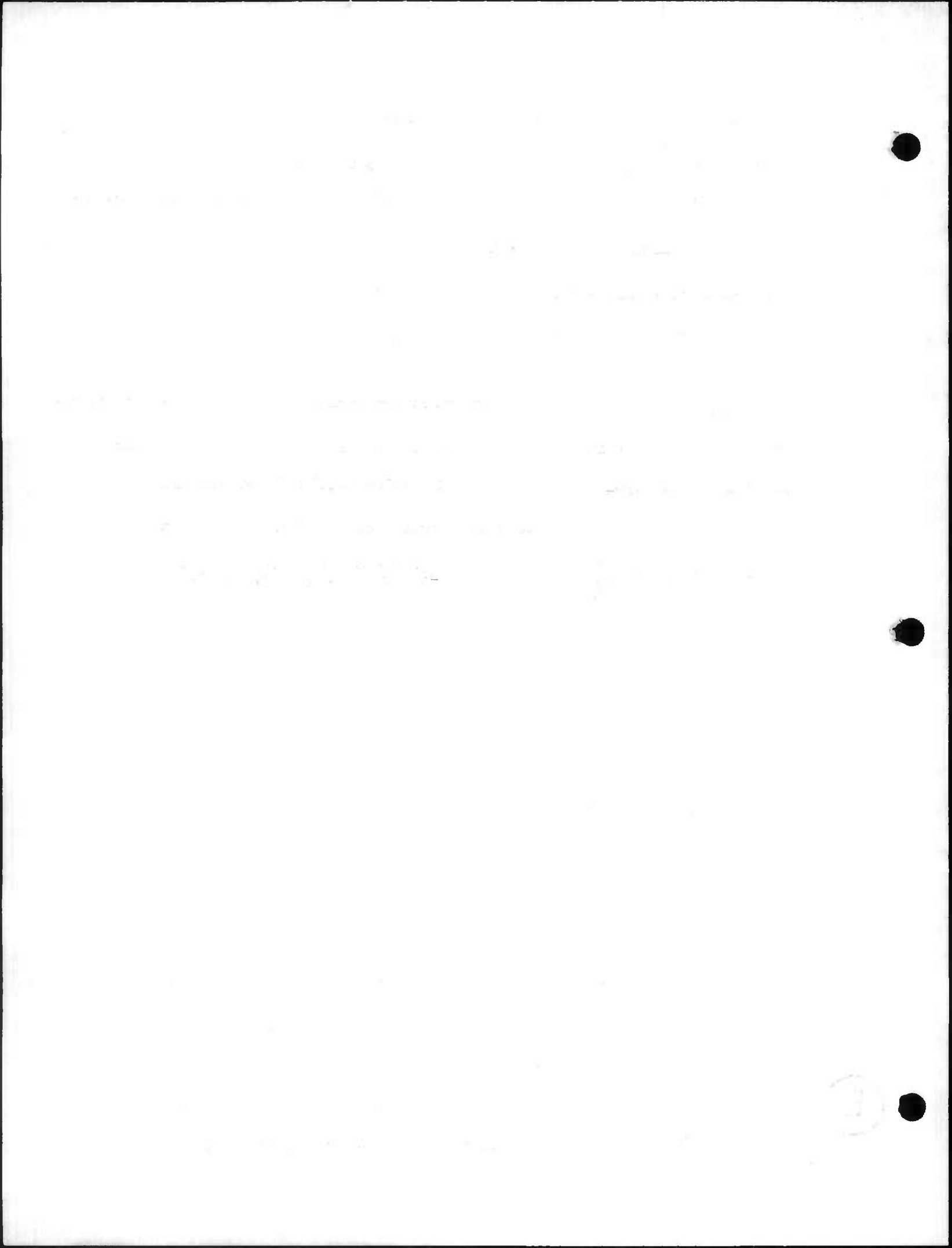
State of Maryland / Department of Health and Mental Hygiene

97 23898

## Certificate of Death

Reg. No.

|  |  |  |  |  |   |
|--|--|--|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Peter White Conover, Jr.</b>  |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>04</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>12:42 P</b>  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY HOSPITAL</b>   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death   |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-90-2079</b>  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>34</b> Yrs.   | If Under 1 Year<br>Months <b>0</b> Days <b>0</b> | If Under 24 Hrs.<br>Hours <b>0</b> Min. <b>0</b>  |
|  | 8. Date of Birth (Month, Day, Year)<br><b>Sept. 26 1962</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |  |  |  |   |
|  | 10a. State<br><b>MD.</b>   | 10b. County<br><b>Baltimore</b>  | 10c. City, Town or Location<br><b>Towson</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  | 10e. Street and Number<br><b>716 Camberley Circle #T1</b>  |  | 10f. Zip Code<br><b>21204</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+)                        |  |   |
|  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction Worker</b>  |  | 16b. Kind of Business/Industry<br><b>Heavy Construction</b>  |  |   |
|  | 17. Father's Name (First, Middle, Last)<br><b>Peter White Conover, Sr.</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Diana McGrath</b>  |  |   |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Catherine Conover/Wife</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>716 Camberley Circle #T1 Towson, MD. 21204</b> |  |   |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Hilltop Service Co.</b>   |  | 20c. Location - City or Town, State<br><b>Towson, MD.</b>   |
|  | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, MD. 21204</b>                                      |  |   |
| Physician<br>/Medical<br>Examiner  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. Multiple Injuries</b><br>Dua to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Dua to (or as a consequence of):</b><br><b>c. Dua to (or as a consequence of):</b><br><b>d. Dua to (or as a consequence of):</b> |  |  |  | Approximate Interval Between Onset and Death  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |
|  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |
|  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)<br><b>9-4-97</b>  |  | 28b. Time of Injury<br><b>12 20 M</b>   |
|  | 28c. Injury at Work?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred<br><b>Crushed between excavator and pipe</b>   |  |   |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Construction site</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>1400 W Lexington St</b>   |  |   |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  | 29b. Signature and title of certifier<br>   |
| State Registrar  | 29c. License number<br><b>OCME</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 06, 1997</b>  |  |   |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Diana R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>                      |  | 32. Registrar's Signature<br>  |  |  |   |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23899

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Dorothy Josephine Conway

2. Date of Death

Month

Day

Year

August 04 1997

3. Time of Death

2:30 A.M.

4e. Facility Name (If not institution, give street and number)

Fallston General Hospital

4b. City, Town, or Location of Death

Fallston

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

217-16-8961

6. Sex

1 ☐ M2 ☒ F

7. Age (In yrs. last birthday)

73

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth (Month, Day, Year)

March 18, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Harford

10c. City, Town or Location

Abingdon

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3404 Tulleys Point Court

10f. Zip Code

21009

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs.

College (1-4 or 5+)

16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Home Maker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Charles F. Klipner

18. Mother's Name (First, Middle, Maiden Surname)

Josephine Klima

19e. Informant's Name/Relationship (Type, Print)

Arden R. Conway / Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3404 Tulleys Point Court Abingdon, Md. 21009

20e. Method of Disposition

1 ☒ Burial2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evergreen Memorial Gds. 8/6/97

Date

20c. Location - City or Town, State

Finksburg, Maryland

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

1050 York Road

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

UREMIA

Approximate Interval Between Onset and Death

5 DAYS

Due to (or as a consequence of):

CHRONIC RENAL FAILURE

5 YEARS

Due to (or as a consequence of):

DIABETIC NEPHROPATHY

Due to (or as a consequence of):

DIABETES MELLITUS.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

OSTEOMYELITIS, CUBOID BONE

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24e. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending investigation2 ☐ Accident3 ☐ Suicide4 ☐ Homicide6 ☐ Could not be determined

28e. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Andrew Nowakowski MD

29c. License number

D08096

29d. Date signed (Month, Day, Year)

AUGUST 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ANDREW NOWAKOWSKI MD 125 N. MAIN ST BEL AIR, MD 21038

31. Date (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia [Signature]

State Registrar

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

5



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23900**  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

SUSIE COBEY

2. Date of Death

August 1, 1997

Day

Year

3. Time of Death

1203 PM

4a. Facility Name (If not institution, give street and number)

HEARTLAND NURSING HOME

4b. City, Town, or Location of Death

Hyattsville

4c. County of Death

Prince Georges

5. Social Security Number

577-54-2171

6. Sex

1 ☐ M ☒ F

7. Age (In yrs. last birthday)

92 Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Apr. 13, 1905

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

D.C.

10b. County

none

10c. City, Town or Location

Washington

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

4514 14th Street, N.W.

10f. Zip Code

20010

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: Black

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

6

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Domestic

17. Father's Name (First, Middle, Last)

James Spencer Cobey

18. Mother's Name (First, Middle, Maiden Surname)

Lucy Holdman

19a. Informant's Name/Relationship (Type, Print)

Melvin M. Cobey son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6007 Elnendorf Dr. Suitland, Md. 20746

20a. Method of Disposition

☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Maryland Nat'l Mem. Pk

Date

8/6

20c. Location - City or Town, State

Laurel, Md.

21. Signature of Funeral Service Licensee

Bernard Hunt

22. Name and Address of Facility

Hunt Funeral Home

1420 34th St. S.E. Wash. D.C. 20020

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. ALZHEIMER'S DISEASE

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

YEARS

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Peripheral vascular Disease

Dysphagia due to Dementia

Arteriosclerosis

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

26. Place of Death (Check only one)

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)

N/A

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Paul Devore M.D.

29c. License number

D01852

29d. Date signed (Month, Day, Year)

August 1, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Paul Devore, M.D. 6500 Riggs Rd. Hyattsville, Md.

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Anderson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
the Medical Examiner, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit  
document.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





97-4201-510

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23901

ITEM: 12,20b,c 28b,28f per DR,&amp;FH G-750 8-7-97

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |   |  |
|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James C. Chase</b>   |   |  |   | 2. Date of Death<br>Month <b>7</b> Day <b>27</b> Year <b>97</b>  |  | 3. Time of Death<br><b>8:14pm</b>                                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>   |   |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>na</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-36-1220</b>   |   | 6. Sex<br><b>M</b> <input type="checkbox"/> F <input type="checkbox"/>   | 7. Age (In yrs. last birthday)<br><b>47</b> Yrs. <input type="checkbox"/> Months <input type="checkbox"/> Days    | 8. Date of Birth (Month, Day, Year)<br><b>5/28/50</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>S. Carolina</b>          |  |
|  | Usual Residence of Decedent   |   |  |   | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>na</b>  |  |
| To Be Completed by Funeral Director  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |  |
|  | 10e. Street and Number<br><b>810 JONQUIL AVE</b>  |   |  |   | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>United States</b>                   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Give Year or Dates: <b>Army</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>High</b> College (1-4 or 5+) <b>some</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>                                |   | 16b. Kind of Business/Industry<br><b>Bethlehem Steel Educational</b>   |  |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>George</b>  |   |  |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>Bernice Williams</b>   |  |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Joan Jarrett - sister</b>  |   |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5810 Jonquil Ave. Balto MD 21215</b> |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>MT ZION CH</b>   |   | 20c. Location - City or Town, State<br><b>ANSDOWN, MD</b>  |  | 20d. Date<br><b>7-30-97</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Dale March</b>  |   |  |   | 22. Name and Address of Facility<br><b>Wm. C. March - 4300 Wabash Ave.</b>   |  |   |  |
|  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |   |  |   |  |  |   |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Intracranial hemorrhage</b><br>Due to (or as a consequence of):<br>b. <b>massive head trauma</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Seizure disorder</b>  |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)<br><b>7/26/97</b>  |  | 28b. Time of Injury<br><b>200 PM</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28d. Describe how injury occurred<br><b>Fell &amp; fell, hit head</b>  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>street</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>5810 JONQUIL AVE BALTI, MD</b> |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   |   |  |   |  |  |   |  |
| 29b. Signature and title of certifier<br><b>R. Cohen</b><br><b>Attending Neurosurgeon</b>  |   |   |  | 29c. License number<br><b>D16353</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>7/27/97</b>  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>RONALD J. COHEN MD, Sinai Hosp., Balto. MD</b>  |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |   | 32. Registrar's Signature<br><b>Randall</b>   |  |   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



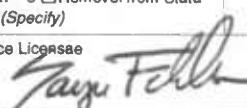
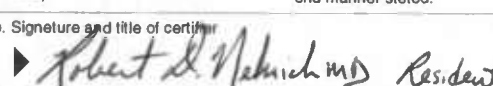
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23902

## Certificate of Death

Reg. No.

|  |  |   |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
|--|--|---|---|---|---|---------------------------------|---|--|--|---|---|---|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Hilda Cohen</b>                                       |   |   |   | 2. Date of Death<br>Month <b>August</b> Day <b>5</b> Year <b>1997</b> |                                 |   |  | 3. Time of Death<br><b>05:45 AM</b>                        |   |   |   |   |  |  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital of Baltimore</b> |   |   |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>              |                                 |   |  | 4c. County of Death<br><b>Baltimore City</b>               |   |   |   |   |  |  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-28-9242</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F                    |   | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.                      |                                 | 8. Date of Birth (Month, Day, Year)<br><b>January 1, 1924</b> |  | 9. Birthplace (State or Foreign Country)<br><b>GERMANY</b> |   |   |   |   |  |  |  |
|  | Usual Residence of Decedent  |   |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore City</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>   |   |                                 |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |   |   |  |  |  |
| 10e. Street end Number<br><b>6024 WOODCREST AVE.</b>   |  |   |   | 10f. Zip Code<br><b>21209</b>   |   |                                 |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |   |   |   |  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |   |                                 |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |   |   |   |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) _____  |  |   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>TEACHER</b>   |   |                                 |   | 16b. Kind of Business/Industry<br><b>HEBREW SCHOOLS</b>  |  |   |   |   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>MEIR STERN</b>   |  |   |   | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>HEDWIG ROTH</b>   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>WERNER COHEN (HUSBAND)</b>  |  |   |   | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6024 WOODCREST AVE. BALTIMORE, MD 21209</b>   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>CHEVRA AHAVAS CHESED</b>   |   | Date<br><b>8/5/97</b>           |   | 20c. Location - City or Town, State<br><b>RANDALLSTOWN, MD</b>   |  |   |   |   |   |  |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 REISTERSTOWN RD., PIKESVILLE, MD 21208</b>   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td rowspan="4">           {         </td> <td>e. <b>Respiratory Failure</b><br/>Due to (or as a consequence of):</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/> <b>Seven days</b><br/><br/> <b>Ten years</b> </td> </tr> <tr> <td>b. <b>Metastatic Breast Cancer</b><br/>Due to (or as a consequence of):</td> </tr> <tr> <td>c. _____<br/>Due to (or as a consequence of):</td> </tr> <tr> <td>d. _____<br/>Due to (or as a consequence of):</td> </tr> </table> |  |   |   |   |   |                                 |   |  |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | { | e. <b>Respiratory Failure</b><br>Due to (or as a consequence of): | Approximate Interval Between Onset and Death<br><br><b>Seven days</b><br><br><b>Ten years</b> | b. <b>Metastatic Breast Cancer</b><br>Due to (or as a consequence of): | c. _____<br>Due to (or as a consequence of): | d. _____<br>Due to (or as a consequence of): |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last  | {  | e. <b>Respiratory Failure</b><br>Due to (or as a consequence of):   | Approximate Interval Between Onset and Death<br><br><b>Seven days</b><br><br><b>Ten years</b> |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
|  |  | b. <b>Metastatic Breast Cancer</b><br>Due to (or as a consequence of):  |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
|  |  | c. _____<br>Due to (or as a consequence of):  |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
|  |  | d. _____<br>Due to (or as a consequence of):  |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |   |   |                                 |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |   |   |   |  |  |  |
|  |  |   |   |   |   |                                 |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |   |   |  |  |  |
|  |  |   |   |   |   |                                 |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |   |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b> |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |   |   |  |  |  |
|  |  |   |   | 28d. Describe how Injury occurred   |   |                                 |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |   |   |   |  |  |  |
|  |  |   |   | 28f. Location (Street end Number or Rural Route Number, City or Town, State)  |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 29b. Signature and title of certifier<br> <b>Resident</b>   |  |   |   | 29c. License number   |   |                                 |   | 29d. Date signed (Month, Day, Year)<br><b>August 5, 1997</b>   |  |   |   |   |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Robert D. Nekrich MD 2401 West Belvedere Avenue Baltimore, MD</b>   |  |   |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |   |   |   |   |                                 |   |  |  |   |   |   |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.


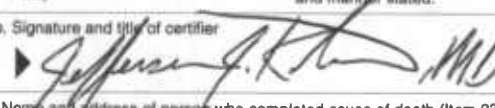
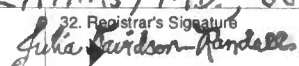
State of Maryland / Department of Health and Mental Hygiene

97 23903

Item16b 8-7-97 FilmG750 W.H.Per F/H

## Certificate of Death

Reg. No.

|  |  |   |  |  |   |  |  |   |
|--|--|---|--|--|---|--|--|---|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>ALAN COHEN</b>                                    |   |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>5</b> Year <b>1997</b> |  | 3. Time of Death<br><b>9:55 PM</b>   |   |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>5813 GREENSPRING AVENUE</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>              |  | 4c. County of Death<br><b>N/A</b>  |   |
| Funeral<br>Director  | 5. Social Security Number<br><b>212-20-0046</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.   | If Under 1 Year<br>Months Days  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>FEB. 22, 1924</b>                                    | 9. Birthplace (State or Foreign Country)<br><b>MD</b> |
|  | Usual Residence of Decedent  |   |  |  |   |  |  |   |
| 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |   |
| 10e. Street and Number<br><b>5813 GREENSPRING AVENUE</b>   |  |   |  | 10f. Zip Code<br><b>21209</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |   |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>WWII</b>   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4or 5+)<br><b>2</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>OWNER</b>  |   | 16b. Kind of Business/Industry Company<br><b>RANDALLSTOWN LUMBER CO</b>  |  |   |
| 17. Father's Name (First, Middle, Last)<br><b>MEYER COHEN</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>LYDIA KOLKER</b>   |   |  |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>ESTELLE G. COHEN (WIFE)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5813 GREENSPRING AVE; BALTIMORE, MD 21209</b>  |   |  |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>   |  | Date<br><b>8-6-97</b>  |   | 20c. Location - City or Town, State<br><b>REISTERSTOWN, MD</b>   |  |   |
| 21. Signature of Funeral Service Licensee<br>  |  |   |  | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS, INC.<br/>8900 REISTERSTOWN RD; PIKESVILLE, MD 21208</b>  |   |  |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Cardiac Arrest</b><br>Due to (or as a consequence of):<br>b. <b>Anemia</b><br>Due to (or as a consequence of):<br>c. <b>Myelofibrosis</b><br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>10 months</b><br><b>11 years</b> |  |   |  |  |   |  |  | Approximate Interval Between Onset and Death          |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |
|  |  |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |
|  |  |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred                     |
|  |  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   |  |  |   |
|  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |  |   |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  | 29b. Signature and title of certifier<br> <b>MD.</b>   |  |  |   |  |  |   |
|  |  | 29c. License number<br><b>D43102</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>Aug. 5, 1997</b>   |   |  |  |   |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JEFFERSON J. KATIMS, MD; 6637 Charlesway, Towson MD 21204</b>   |  |   |  |  |   |  |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  | 32. Registrar's Signature<br>  |  |  |   |  |  |   |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23904

## Certificate of Death

Reg. No.

|   |   |   |                          |  |  |   |  |  |  |  |  |
|---|---|---|--------------------------|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Ronald Cheezum</b>                       |   |                          |  |  |   | 2. Date of Death<br>Month <b>July</b> Day <b>29</b> Year <b>1997</b> |  | 3. Time of Death<br><b>1:55 pm</b>                         |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b> |   |                          |  |  |   | 4b. City, Town, or Location of Death<br><b>Baltimore</b>             |  | 4c. County of Death<br><b>—</b>                            |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>220-36-86-77</b>  |   | 6. Sex<br><b>1 M 2 F</b> |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs. |   | 8. Date of Birth (Month, Day, Year)<br><b>Nov. 4, 1938</b>           |  | 9. Birthplace (State or Foreign Country)<br><b>unknown</b> |  |  |
|   | Usual Residence of Decedent   |   |                          |  |  |   |  |  |  |  |  |
| 10a. State<br><b>Maryland</b>   |   | 10b. County<br><b>Baltimore</b>   |                          | 10c. City, Town or Location<br><b>Baltimore County</b>   |  |   |  | 10d. Inside City Limits<br><b>1 Yes 2 No</b>   |  |  |  |
| 10e. Street and Number<br><b>6718 Chisolm Drive</b>   |   |   |                          | 10f. Zip Code<br><b>21207</b>  |  |   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  |
| 11. Marital Status<br><b>1 X Navar Married 2 Married</b><br><b>3 Widowed 4 Divorced</b>   |   | 12. Was Decedent Ever In U.S. Armed Forces?<br><b>1 Yes 2 No</b><br>If Yes, Give Year or Dates: |                          | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1 Yes 2 X No Specify:</b>           |  |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12) unknown</b><br><b>College (1-4 or 5+) unknown</b>   |   |   |                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>unknown</b>                            |  |   |  | 16b. Kind of Business/Industry<br><b>unknown</b>   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |   |   |                          |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>unknown</b>   |  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Rose Robinson/sister</b>   |   |   |                          |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>315 Ingleside Avenue, Baltimore, Maryland 21228</b> |  |  |  |  |  |
| 20a. Method of Disposition<br><b>1 X Burial 2 Cremation 3 Removal from State</b><br><b>4 Donation 5 X Other (Specify) in state</b>  |   |   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>in state</b>  |  | 20c. Location - City or Town, State   |  | 20d. Date  |  |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |   |   |                          |  |  | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</b>                                   |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Immediata Cause (Final disease or condition resulting in death)</b><br><b>a. Sepsis</b><br>Due to (or as a consequence of):<br><b>b.</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b><br><b>Sequitally list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</b> |   |   |                          |  |  |   |  |  |  | Approximate Interval Between Onset and Death<br><b>unknown</b> |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>cerebrovascular accident</b>   |   |   |                          |  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1 Yes 2 No 3 Probably 4 X Unknown</b>   |  |  |  |
|   |   |   |                          |  |  |   |  | 24a. Was an autopsy performed?<br><b>1 Yes 2 X No</b>  |  |  |  |
|   |   |   |                          |  |  |   |  | 24b. Were autopsy findings available prior to completion of causa of death?<br><b>1 Yes 2 No</b>   |  |  |  |
| 25. Was causa referred to medical examiner?<br><b>1 Yes 2 X No</b>  |   |   |                          | 26. Place of Death (Check only one)<br>Hospital: <b>1 X Inpatient 2 ER/Outpatient 3 DOA</b> Other: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b> |  |   |  |  |  |  |  |
| 27. Manner of Death<br><b>1 X Natural 2 Accident 3 Suicide 4 Homicide</b><br><b>5 Pending investigation 6 Could not be determined</b>   |   |   |                          | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><b>1 Yes 2 No</b>  |  |  |  |
|   |   |   |                          | 28d. Describe how injury occurred  |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><b>1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the causa(s) and manner as stated.</b><br><b>2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner as stated.</b>   |   |   |                          | 29b. Signature and title of certifier<br><b>Usha Sunkara MD</b>  |  |   |  | 29c. License number<br><b>D 21187</b>  |  |  |  |
|   |   |   |                          | 29d. Date signed (Month, Day, Year)<br><b>July 29, 1997</b>  |  |   |  | 30. Name and address of person who completed causa of death (Item 23a) (Type, Print)<br><b>USHA SUNKARA, SINAI HOSPITAL, BALTIMORE, Maryland</b> |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |   |   |                          | 32. Registrar's Signature<br><b>John Gordon</b>  |  |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner





AM  
DARYL  
DOUGLAS

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23905

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

Daryl Douglas

2. Date of Death

Month Day Year  
AUGUST 02, 1997

3. Time of Death

9:20 P

4a. Facility Name (If not institution, give street and number)

MEMORIAL HOSPITAL ICU

4b. City, Town, or Location of Death

N/A

4c. County of Death

ALLEGANY

5. Social Security Number

219-32-7213

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

39 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year

Nov. 2, 1957

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State  
Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

3004 Rosalind Ave.

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  
1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

Laborer

16b. Kind of Business/Industry

Pro-Trak

17. Father's Name (First, Middle, Last)

Milburn Douglas

18. Mother's Name (First, Middle, Maiden Surname)

Patricia Newman

19a. Informant's Name/Relationship (Type, Print)

Mr. Milburn Douglas (Father)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3004 Rosalind Ave. Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

King Memorial

Date

8/7/97

20c. Location - City or Town, State

Balto. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home

2225 W. North Ave. Balto. Md. 21216

23a. Pertinent enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. Multiple Injuries

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)  
8-2-97

28b. Time of Injury

12 13 M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

Other  
auto coll. 310

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Roadway

28f. Location (Street and Number or Rural Route Number, City or Town, State)

I 68

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

David R. Fowler

29c. License number

OCME

29d. Date signed (Month, Day, Year)

AUGUST 03, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler 111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John E. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23906

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

James A. Dolphin, Jr.

2. Date of Death

Aug.

Day 2 Year 1997

3. Time of Death

2:00 AM

4a. Facility Name (If not institution, give street and number)

6133 Gatsby Green

4b. City, Town, or Location of Death

Columbia

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

179-32-3050

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 12, 1941

9. Birthplace (State or Foreign Country)

PA

Usual Residence of Decedent

10a. State

MD

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

6133 Gatsby Green

10f. Zip Code

21045

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5+16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Electrical Engineer

16b. Kind of Business/Industry

Mykotronx

17. Father's Name (First, Middle, Last)

James A. Dolphin

18. Mother's Name (First, Middle, Maiden Surname)

Anna Neary

19a. Informant's Name/Relationship (Type, Print)

Joanne Dolphin (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6133 Gatsby Green, Columbia, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Columbia Mem. Park

Date

Aug. 6 1997

20c. Location - City or Town, State

Clarksville, MD

21. Signature of Funeral Service Licensee

Robert Eugene Baker

22. Name and Address of Facility

Witzke Funeral Homes, Inc.  
5555 Twin Knolls Rd. Columbia, MD 2104523a. Part I. Enter the disease, or complication, or event caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. pancreatic cancer  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

10/96

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jacob Cherian MD

29c. License number

DS0973

29d. Date signed (Month, Day, Year)

Aug 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JACOB CHERIAN Two Knoll North Dr. Columbia Md 21045

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo Hospital or Attending Physician: The law requires that the death certificate be executed  
24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23907

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Gregory Ellis

2. Date of Death

Month August Day 4 Year 1997

3. Time of Death

11:40pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

John Hopkins Bayview Medical Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

131-44-6479

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

42 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
February 23, 1955

9. Birthplace (State or Foreign Country)

New York

Usual Residence of Decedent

10a. State  
Maryland

10b. County

Howard

10c. City, Town or Location

Columbia

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5609 Vantage Point Road

10f. Zip Code

21044

10g. Citizen of What Country?

U.S.A

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: African-American

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Correction Officer

16b. Kind of Business/Industry

State Dept of N.Y.

17. Father's Name (First, Middle, Last)

Daniel Ellis

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Rokster

19a. Informant's Name/Relationship (Type, Print)

Ruth Ellis

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1229 Franklin Avenue Bronx, N.Y.

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Spear Hollow Cemetery

Date

8/11/97

20c. Location - City or Town, State

Tarrytown, N.Y.

21. Signature of Funeral Service Licensee

W. E. Hamell Jr.

22. Name and Address of Facility

Unity Funeral Chapel 108 W. North Ave  
21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

Infection

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 week

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Acquired Immunity Deficiency Syndrome

Due to (or as a consequence of):

unknown

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. E. Hamell Jr. MD

29c. License number

97026

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Johns Hopkins Bayview Medical Center, Baltimore, Maryland

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John F. Anderson

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23908

## Certificate of Death

Reg. No.

Item 26, 28a per MEO Film G750 8-6-97 rja  
WILLIAM FISHER

|  |  |  |  |  |   |  |   |  |
|--|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>William Charles Fisher</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 26 1997</b>   |  | 3. Time of Death<br><b>3:29 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>SINAI HOSPITAL</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>n/a</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-26-8092</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>73</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct 13, 1923</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>n/a</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director                                  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  |  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b><br><b>1 1/2 years</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cab Driver</b>  |  |
|  | 16b. Kind of Business/Industry<br><b>Yellow Cab Company</b>  |  |  |  | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |
|  | 19a. Informant's Name/Relationship (Type, Print) <b>wife</b><br><b>Joyce M. Fisher</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3502 Woodland Avenue Baltimore, MD 21215</b>  |  |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD Veterans Cemetery/Garrison</b>                                    |  | 20c. Location - City or Town, State<br><b>Aug. 1st Owings Mills, MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |  |  | 22. Name and Address of Facility<br><b>Nutter Funeral Homes, Inc.</b><br><b>2501 Gwynns Falls Pkwy</b><br><b>Baltimore, Maryland 21216</b>        |  |   |  |
|  | 23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Exsanguination from Left Leg Hypertension Sept Site</b><br>Due to (or as a consequence of):  |  |  |  |   |  |   |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  |   |  |   |  |
|  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |   |  |
| Physician<br>/Medical<br>Examiner                                    | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |   |  |   |  |
|  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |  |  |   |  |   |  |
|  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |  |  |   |  |   |  |
|  | 28a. Date of Injury (Month, Day, Year)<br><b>7-26-97</b>   |  |  |  |   |  |   |  |
|  | 28b. Time of Injury<br><b>Unknown</b>  |  |  |  |   |  |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  |   |  |   |  |
|  | 28d. Describe how Injury occurred<br><b>Subject bled from surgical site</b>  |  |  |  |   |  |   |  |
|  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>home</b>  |  |  |  |   |  |   |  |
|  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>3502 Woodland Avenue Baltimore, Maryland</b>  |  |  |  |   |  |   |  |
|  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. |  |  |  |   |  |   |  |
| State<br>Registrar   | 29b. Signature and title of certifier<br><i>Theodore M. King M.D.</i>  |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 28, 1997</b>   |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |   |  |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>AUG 06 1997</b>  |  |  |  | 32. Registrar's Signature<br><i>[Signature]</i>   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

541





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23909

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Norman Edward Fleming

2. Date of Death

Month

Day

Year

3. Time of Death

10:30 AM

4a. Facility Name (If not institution, give street and number)

13322 Pruitt Lane

4b. City, Town, or Location of Death

Princess Anne

4c. County of Death

Somerset

Funeral  
Director

5. Social Security Number

213-03-5042

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

July 4, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Somerset

10c. City, Town or Location

Princess Anne

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

13322 Pruitt Lane

10f. Zip Code

21853

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

8

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Grocery Store

17. Father's Name (First, Middle, Last)

William Steven Fleming

18. Mother's Name (First, Middle, Maiden Summa)

Susie Francis Bradley

19a. Informant's Name/Relationship (Type, Print)

Margaret Fleming/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

RD 2, Box 365, Laurel, Delaware 19956

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a.

Due to (or as a consequence of):

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

29c. License number

D29105

29d. Date signed (Month, Day, Year)

7/14/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

C.J. Huddleston 106 Mulford St Salisbury, md 21801

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Anderson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and conclusively filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

97 23910

Reg. No.

|   |   |  |                                 |   |  |  |   |  |
|---|---|--|---------------------------------|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>GERALD FREDERICK</b>                           |  |                                 |   | 2. Date of Death<br>Month <b>JULY</b> Day <b>22</b> Year <b>1997</b> |  | 3. Time of Death<br><b>08:00 PM</b>                                 |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>5913 FISHER ROAD #11</b> |  |                                 |   | 4b. City, Town, or Location of Death<br><b>TEMPLE HILLS</b>          |  | 4c. County of Death<br><b>PRINCE GEORGES</b>                        |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>388-30-6466</b>   |  | 6. Sex<br><b>1</b> M <b>2</b> F |   | 7. Age (In yrs. last birthday)<br><b>63</b> Yrs.                     |  | 8. Date of Birth<br>Month <b>JUN</b> Day <b>25</b> Year <b>1934</b> |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>OSHKOSH, WI</b>                                |  | 10a. State<br><b>MD.</b>        |   | 10b. County<br><b>PRINCE GEORGES</b>                                 |  | 10c. City, Town or Location<br><b>TEMPLE HILLS</b>                  |  |
| 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No   |   | 10e. Street and Number<br><b>5913 FISHER RD. #11</b>   |                                 | 10f. Zip Code<br><b>20748</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |   |  |
| 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:   |                                 | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b> |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>STAFF SERGEANT</b>   |                                 | 16b. Kind of Business/Industry<br><b>U.S. AIR FORCE</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>GEORGE FREDERICK</b>   |   |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DELLA VOWELS</b>  |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>EVA MAUD</b>  |                                 | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2113 NORTH POINT ST. OSHKOSH, WI. 54901</b>   |  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)   |   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |   | 20c. Date<br><b>AUG 6 1997</b>   |                                 | 20d. Location - City or Town, State<br><b>BALTO. CO. MD.</b>  |  | 21. Signature of Funeral Service Licensee<br><i>Thomas J. Atch Jr.</i>   |   |  |
| 22. Name and Address of Facility<br><b>SKALDA FH. 2829 HUDSON ST. BALTIMORE, MD. 21224</b>  |   | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> |                                 | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> <input checked="" type="checkbox"/> Probably <b>4</b> Unknown   |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> <input checked="" type="checkbox"/> No   |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                                     |   | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No   |                                 | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> Other (Specify)  |  | 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined   |   |  |
| 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |                                 | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  | 28d. Describe how injury occurred  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                 | 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><i>Julia Davidson-Randall</i>   |   |  |
| 29c. License number<br><b>D33954</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 23, 1997</b>  |                                 | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>MARIO F. GOLIE JR MD 3001 HOSPITAL DRIVE, CHEVERLY, MARYLAND 20785</b>   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |   |  |
| 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |   | 33. State Registrar  |                                 | 34. Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21215-0020   |  | 35. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate. |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23911

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELAINE L. FRANZ

2. Date of Death

Month Day Year  
JULY 30, 1997

3. Time of Death

0431

4a. Facility Name (If not institution, give street and number)

ATLANTIC GENERAL HOSP.

4b. City, Town, or Location of Death

BERLIN

4c. County of Death

WORCHESTER

5. Social Security Number

175-26-8525

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB. 12, 1932

9. Birthplace (State or Foreign Country)

ALLENTOWN, PA.

Usual Residence of Decedent

10a. State

PA.

10b. County

BUCKS

10c. City, Town or Location

FEASTERVILLE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

318 PHEASANT RUN

10f. Zip Code

19053

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

5+

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SCHOOL TEACHER

16b. Kind of Business/Industry

EDUCATION

17. Father's Name (First, Middle, Last)

ALTON F. WAGAMAN

18. Mother's Name (First, Middle, Maiden Surname)

PAULINE A. OSWALD

19a. Informant's Name/Relationship (Type, Print)

FRANK M. FRANZ JR.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

318 PHEASANT RUN FEASTERVILLE, PA. 19053

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

PHILADELPHIA CREMATORY

Date

AUG 4 1997

20c. Location - City or Town, State

PHILADELPHIA PA.

21. Signature of Funeral Service Licensee

Thomas J. Skarda Jr.

22. Name and Address of Facility

SKARDA FH. 2829 HUDSON ST. BALTO., MD. 21224

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. pulmonary embolism

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

minutes

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. hypertension

Due to (or as a consequence of):

years

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

R. Cragway MD

29c. License number

D28466

29d. Date signed (Month, Day, Year)

4/30/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROY CRAGWAY JR MD 9733 KATHMAN DR BERLIN MD 21011

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

Item6

State of Maryland / Department of Health and Mental Hygiene

97 23912

Item20b 8-7-97 FilmG750 W.H.Per F/H

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sylvia Jean Feldman

2. Date of Death

August 4, 1997

3. Time of Death

6:10 p.m.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

218-30-5308

6. Sex

F

7. Age (in yrs. last birthday)

86

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

SEPT 17, 1910

9. Birthplace (State or Foreign Country)

NEW YORK

Usual Residence of Decedent

10a. State  
MARYLAND10b. County  
N/A10c. City, Town or Location  
BALTIMORE

10d. Inside City Limits

1 Yes 2 No

10e. Street and Number

3601 CLARKS LANE, APT. PH G

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 Never Married 2 Married  
3 Widowed 4 Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 Yes 2 No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

NURSE

16b. Kind of Business/Industry

NURSING

17. Father's Name (First, Middle, Last)

PHILLIP MORTON LIVINGSTON

18. Mother's Name (First, Middle, Maiden Surname)

DORA MATILDA MILLER

19a. Informant's Name/Relationship (Type, Print)

MR. MORRIS FELDMAN (HUSBAND)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3601 CLARKS LANE, APT. PH-G BALTIMORE, MD 21215

20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State  
4 Donation 5 Other (Specify)

20b. Place of Disposition (Name of or other place)

Mikro

MIKOR KODESH BETH ISRAEL-8-6-1997- BALTIMORE, MD

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Michael Kugler

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 Reisterstown Rd Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Cardiogenic Shock

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 hour

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Myocardial Infarction

Due to (or as a consequence of):

13 days

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aortic Stenosis

Coronary Atherosclerotic Disease

Chronic Renal Insufficiency

23b. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

1 Yes 2 No

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

25. Was case referred to medical examiner?

1 Yes 2 No

Hospital:

1 Inpatient

2 ER/Outpatient

3 DOA

Other:

26. Place of Death (Check only one)

4 Nursing Home

5 Residence

6 Other (Specify)

27. Manner of Death

1 Natural 2 Accident 3 Suicide 4 Homicide  
5 Pending Investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 Yes 2 No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Medical Examiner

2 To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Charles M. Heaton, M.D.

29c. License number

AS-2402321-CH-9347

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Charles M. Heaton, M.D.

Sinai Hospital Baltimore, Maryland

31. Date filed (Month, Day, Year)

AUG 07 1997

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23913

## Certificate of Death

Reg. No.

|   |   |  |   |   |  |                                       |   |  |
|---|---|--|---|---|--|---------------------------------------|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>PEARL GUY</b>  |  |   | 2. Date of Death<br>Month Day Year<br><b>JULY 30, 1997</b>      |  | 3. Time of Death<br><b>23:27</b>      |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CALVERT MEMORIAL HOSPITAL</b>  |  |   | 4b. City, Town, or Location of Death<br><b>PRINCE FREDERICK</b> |  | 4c. County of Death<br><b>CALVERT</b> |   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>280-K-7867</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>88</b> Yrs.   |                                       | 8. Date of Birth (Month, Day, Year)<br><b>DEC-23, 1908</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>CONWAY, PA.</b>  |  | 10a. State<br><b>MD.</b>  |   | 10b. County<br><b>CALVERT</b>  |                                       | 10c. City, Town or Location<br><b>CHESAPEAKE BEACH</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>3529 CHRISTIANA COURT</b>  |   | 10f. Zip Code<br><b>20732</b>  |                                       | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |                                       | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>3</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>NURSE</b>   |   | 16b. Kind of Business/Industry<br><b>HEALTH CARE</b>   |                                       | 17. Father's Name (First, Middle, Last)<br><b>DOMENICK CATALUCCI</b>  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ROSEANNA CUDDA</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>LELAND S. GUY JR.</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>649 CATHYANN DA. BOARDMAN, OH. 44512</b>   |                                       | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>LISBON CEM.</b>  |  | 20c. Date<br><b>8-2-97</b>  |   | 20d. Location - City or Town, State<br><b>LISBON, OH.</b>  |                                       | 21. Signature of Funeral Service Licensee<br><b>Thomas J. Skarda Jr.</b>  |  |
|   | 22. Name and Address of Facility<br><b>SKARDA FH- 2829 HUDSON ST BALTIMORE, MD. 71224</b>   |  | 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of):<br>b. <b>DIABETES</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   | Approximate Interval Between Onset and Death<br><b>3 DAYS YEARS</b>  |                                       | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |                                       | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>  |                                       | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how Injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                       | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D29657</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>7/31/97</b>  |                                       | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Charles A. Judge, M.D. Prince Frederick, MD. 20678</b>   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |   | 33. Date of Death (Month, Day, Year)<br><b>JULY 30, 1997</b>   |                                       | 34. Time of Death<br><b>23:27</b>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



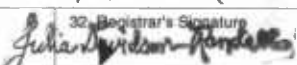
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23914

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |  |
|---|---|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Frances Garbo</b>  |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>4</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>6:45 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>717 Maiden Choice Lane</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Catonsville</b>   |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217-22-9974</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>85</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>May 5, 1912</b>                                   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Catonsville</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br><b>717 Maiden Choice Lane</b>   |  | 10f. Zip Code<br><b>21228</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> Collega (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Associate</b>   |  | 16b. Kind of Business/Industry<br><b>Hutzlers</b>  |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Salvatore Tringali</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Jennie Zanti</b>   |  |   |  |
| Physician<br>/Medical<br>Examiner             | 19a. Informant's Name/Relationship (Type, Print)<br><b>Rosalie L. Wood (Daughter)</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2805 Pinewick Road Ellicott City, Maryland 21042</b>   |  |   |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>New Cathedral Cemetery</b>   |  | Date<br><b>August 7, 1997</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, Maryland</b>                           |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Witzke Funeral Home of Catonsville, Inc.<br/>1630 Edmondson Avenue Catonsville, Maryland 21228</b>  |  |   |  |
|   | 23a. Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Stomach Cancer</b>  |  |   |  | Approximate Interval Between Onset and Death<br><b>months</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Immediate Cause (Final disease or condition resulting in death)<br><b>Stomach Cancer</b>  |  |   |  | Due to (or as a consequence of):   |  |   |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>Stomach Cancer</b>   |  |   |  | Due to (or as a consequence of):   |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  |
|   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  | 28g. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  | 29b. Signature and title of certifier<br>   |  |   |  |
|   | 29c. License number<br><b>047447</b>  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>August 4, 1997</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Andrew Lewis 711 Maiden Choice Lane Catonsville</b>  |  |   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br>  |  |   |  | 33. Registrar's Signature<br>   |  |   |  |



WRC  
97-4367-510  
LOUIS  
HOLLAND

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23915

Certificate of Death

Reg. No.

|                                     |   |   |  |   |  |   |   |  |  |                                   |  |   |  |
|-------------------------------------|---|---|--|---|--|---|---|--|--|-----------------------------------|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>LOUISE MARY HOLLAND                         |   |  |   | 2. Date of Death<br>Month Day Year<br>AUGUST 05 1997 |   | 3. Time of Death<br>12:25 PM                    |  |  |                                   |  |   |  |
|                                     | 4e. Facility Name (If not Institution, give street and number)<br>3312 W. GARRISON AVE. |   |  |   | 4b. City, Town, or Location of Death<br>BALTIMORE    |   | 4c. County of Death<br>N/A                      |  |  |                                   |  |   |  |
| Funeral<br>Director                 | 5. Social Security Number<br>214-18-0746  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>95 Yrs.            |   | 8. Date of Birth (Month, Day, Year)<br>5-2-1902 |  | 9. Birthplace (State or Foreign Country)<br>Md |                                   |  |   |  |
|                                     | Usual Residence of Decedent   |   |  |   | 10e. State<br>Md                                     |   | 10b. County<br>N/A                              |  | 10c. City, Town or Location<br>Baltimore       |                                   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No |   |  |
| To Be Completed by Funeral Director |   | 10e. Street and Number<br>3312 W. Garrison Avenue   |  |   |  | 10f. Zip Code<br>21215  |   | 10g. Citizen of What Country?<br>U S A   |  |                                   |  |   |  |
|                                     |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No-<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:   |   | 14. Race - American Indian, Black, White, etc.<br>Specify: Black                     |  |                                   |  |   |  |
|                                     |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>7th grade   |  | College (1-4 or 5+)<br>N/A  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Janitor  |   | 16b. Kind of Business/Industry<br>U S F & G  |  |                                   |  |   |  |
|                                     |   | 17. Father's Name (First, Middle, Last)<br>William Carroll  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>Emma Hall  |   |  |  |                                   |  |   |  |
|                                     |   | 19a. Informant's Name/Relationship (Type, Print)<br>Lillian Vaughn Granddaughter  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>3312 W. Garrison Avenue Baltimore, Md 21215  |   |  |  |                                   |  |   |  |
|                                     |   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Woodlawn Cemetery   |  | Date<br>8-9-97  |   | 20c. Location - City or Town, State<br>Baltimore, Md                                 |  |                                   |  |   |  |
|                                     |   | 21. Signature of Funeral Service Licensee<br>▶ Gladys Wanes   |  |   |  | 22. Name and Address of Facility<br>March F/H West<br>4300 Wabash Avenue Baltimore, Md 21215  |   |  |  |                                   |  |   |  |
|                                     |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>Arteriosclerotic Cardiovascular Disease<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br><br>Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>SYPHILIS |  |   |  |   |   |  |  |                                   |  |   |  |
|                                     |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br>INSPECTION<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |  |                                   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
|                                     |   | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   |  |  |                                   |  |   |  |
|                                     |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred |  |   |  |
|                                     |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |  |                                   |  |   |  |
|                                     |   | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |   |   |  |  |                                   |  |   |  |
|                                     |   | 29b. Signature and title of certifier<br>Theodore M. King M.D.  |  |   |  | 29c. License number<br>O.C.M.E.   |   | 29d. Date signed (Month, Day, Year)<br>AUGUST 06, 1997                               |  |                                   |  |   |  |
|                                     |   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Theodore King M.D. 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |   |   |  |  |                                   |  |   |  |
|                                     |   | 31. Date filed (Month, Day, Year)<br>AUG 07 1997  |  |   |  | 32. Registrar's Signature<br>▶ L. Davidson-Randall  |   |  |  |                                   |  |   |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,  
The law requires that the death certificate be executed within 24 hours after death.  
To the Hospital or Attending Physician: After this certificate has been signed by the attending physician and completed, it should be filed in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23916

Items: 23a part I, 27 per MEO G-750 8/11/97 dh

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedant's Name (First, Middle, Last)

Kelcia Cierra Hubbard

2. Date of Death

Month Day Year  
MAY 10 1997

3. Time of Death

11.29 AM

4a. Facility Name (If not institution, give street and number)

UNION MEMORIAL HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

none

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

Yrs.

If Under 1 Year

Months Days

2

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

Feb 20, 1997

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedant

10a. State

Maryland

10b. County

Baltimore City

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2506 North Calvert Street

10f. Zip Code

21218

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedant of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedant's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

none

College (1-4 or 5+)

none

18a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

none

16b. Kind of Business/Industry

none

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Melody Berry

19a. Informant's Name/Relationship (Type, Print)

Melody Berry/mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

SUDDEN INFANT DEATH SYNDROME

a. Due to (or as a consequence of):

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient 3 ☐ DOA

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accidental 3 ☐ Suicidal 4 ☐ Homicidal  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

MAY 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 07 1997

111 Penn Street, Baltimore, Maryland 21201

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





JAMES  
HAWKINS

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State of Maryland / Department of Health and Mental Hygiene

97 23917

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |  |
|---|--|--|--|--|---|--|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>JAMES H. HAWKINS SR.</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 19 1997</b>   |  | 3. Time of Death<br><b>5:36 P.M.</b>  |  |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>3823 ST. MARGARET STREET</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>   |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-40-2898</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>56</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>MAR. 24, 1941</b>   |  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MD.</b>   |  | 10a. State<br><b>MD.</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>3823 ST. MARGARET ST.</b>  |  | 10f. Zip Code<br><b>21225</b>   |  |  |
|   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11TH</b> Collage (1-4or 5+)                     |  |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PLUMBER</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>PLUMBING</b>   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>BAILEY HAWKINS</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>DOROTHY BLAIR</b>   |  |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>THOMAS GIEHNER</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>518 S. LEHIGH ST. BALTO. MD. 21224</b>  |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>METRO CREMATORY</b>  |  | 20c. Location - City or Town, State<br><b>JULY 30 1997 BALTO. CO. MD.</b>   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Thomas J. Skarda Jr.</b>   |  |  |  | 22. Name and Address of Facility<br><b>SKARDA FA. 2829 HODSON ST. BALTO. MD. 21224</b>  |  |   |  |  |
| Physician<br>/Medical<br>Examiner             | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br><b>Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d.<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |   |  |   | Approximate Interval Between Onset and Death   |  |
|   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br><b>INSPECTION</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  |  |
|   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |
|   | 29a. Certifier<br>(Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br><b>Stephen S. Radentz, MD</b>   |  |  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>JULY 20, 1997</b>   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Stephen S. Radentz, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |  |  |   |  |   |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |  |  | 32. Registrar's Signature<br><b>Davidson-Randall</b>  |  |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23918

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JEAN G. HOUSTON

2. Date of Death

Aug 01 1997

3. Time of Death

4:38 pm

4a. Facility Name (If not institution, give street and number)

HARBOR HOSPITAL 3001 S. HANOVER ST

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

Funeral  
Director

5. Social Security Number

212-46-4423

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

03/24/1945

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Anne Arundel Co.

10c. City, Town or Location

N/A

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

218 Berlin Avenue

10f. Zip Code

21225

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12th

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Cook

16b. Kind of Business/Industry

Food Services

17. Father's Name (First, Middle, Last)

Albert Bowie, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Edith Bradshaw

19a. Informant's Name/Relationship (Type, Print)

Robert Houston/Husband  
Michael Johnson/Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

218 Berlin Avenue Baltimore, Maryland 21225

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Rest Cemetery

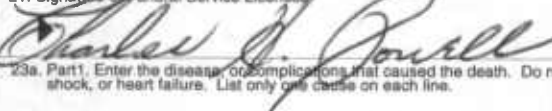
Date

8/11/97

20c. Location - City or Town, State

Harmans, Maryland

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

William C. Brown Community Funeral Home  
1206 W. North Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Systemic lupus erythematosus 6 mos

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and Title of certifier

 MD

29c. License number

D17743

29d. Date signed (Month, Day, Year)

8/5/97

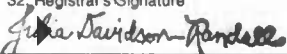
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

L. SEENIVASAN, MD, 606 Hammond Lane, BALTO, MD, 21225

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene **97 23919**  
Certificate of Death

Reg. No.

|   |   |  |   |   |  |  |  |  |  |  |
|---|---|--|---|---|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><i>Maria Ippolito</i>                                   |  |   |   |  |  | 2. Date of Death<br>Month <i>07</i> - Day <i>30</i> - Year <i>97</i> |  | 3. Time of Death<br><i>61</i>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><i>Mariner Health of Bethesda</i> |  |   |   |  |  | 4b. City, Town, or Location of Death<br><i>Bethesda</i>              |  | 4c. County of Death<br><i>Montgomery</i>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><i>578-34-2689</i>   |  | 8. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><i>69</i> Yrs. |  | If Under 1 Year<br>Months Days                                       |  | If Under 24 Hrs.<br>Hours Min.   |  |
|   | 6. Date of Birth (Month, Day, Year)<br><i>04-07-28</i>  |  | 9. Birthplace (State or Foreign Country)<br><i>unknown</i>  |   | 10a. State<br><i>Maryland</i>                    |  | 10b. County<br><i>Montgomery</i>                                     |  | 10c. City, Town or Location<br><i>Gaithersburg</i>   |  |
| Usual Residence of Decedent   |   |  |   |   |  |  |  |  |  |  |
| 10a. State<br><i>Maryland</i>   |   |  | 10b. County<br><i>Montgomery</i>  |   |  | 10c. City, Town or Location<br><i>Gaithersburg</i>   |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
| 10e. Street and Number<br><i>19301 Wakins Mill Road</i>   |   |  |   | 10f. Zip Code<br><i>20879</i>   |  |  |  | 10g. Citizen of What Country?<br><i>U.S.A.</i>   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>   |   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>unknown</i>   |  |  |  | 16b. Kind of Business/Industry<br><i>unknown</i>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><i>unknown</i>   |   |  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>unknown</i>  |  |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><i>unknown</i>  |   |  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>unknown</i>  |  |  |  |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input checked="" type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <i>in state</i>  |   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)  |  | Date   |  | 20c. Location - City or Town, State  |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Ronald S. Wade, Director</i>  |   |  |   |   |  | 22. Name and Address of Facility<br><i>State Anatomy Board, 655 W. Baltimore Street<br/>Baltimore, Maryland 21201</i>  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.<br><i>Renal Failure</i>  |   |  |   |   |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Renal Failure</i><br>Due to (or as a consequence of):<br>b.<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last                                    |   |  |   |   |  |  |  |  |  |  |
| Approximate Interval Between Onset and Death<br><i>month</i>  |   |  |   |   |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |   |  |   |   |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 28d. Describe how injury occurred  |
|   |   |  |   | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |   |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Joe Shub</i>  |   |  |   |   |  | 29c. License number<br><i>020516</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>July 30, 1997</i>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>9410 Old Georgetown Rd. Bethesda, MD 20814</i>   |   |  |   |   |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><i>AUG 07 1997</i>   |   |  |   | 32. Registrar's Signature<br><i>John A. ...</i>   |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



WRC  
97-4338-510  
KENNETH  
JOHNSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

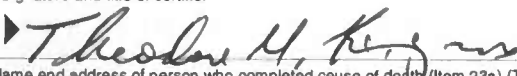
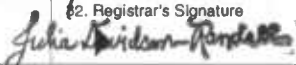
State of Maryland / Department of Health and Mental Hygiene

97 23920

Items: 23a part I, 27, 28a-f per MEO G-750 8/13/97

Reg. No.

Certificate of Death

|   |   |  |   |   |  |   |  |   |  |  |  |  |
|---|---|--|---|---|--|---|--|---|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Kenneth Lamont Johnson</b>   |  |   | 2. Date of Death<br>Month Day Year<br><b>AUGUST 04, 1997</b>  |  |   | 3. Time of Death<br><b>1:35 PM.</b>  |   |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>3954 DOLFIELD AVE.</b>   |  |   | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  |   | 4c. County of Death<br><b>N/A</b>  |   |  |  |  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>219-80-3479</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>36</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 30, 1960</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>MD</b>  |  |  |  |
|   | 10a. State<br><b>MD</b>   |  |   | 10b. County<br><b>-</b>   |  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
| To Be Completed by Funeral Director           | 10e. Street and Number<br><b>5207 Denmore Avenue</b>  |  |   | 10f. Zip Code<br><b>21215</b>   |  |   | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |  |  |  |
|   | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:<br><b>82-86</b> |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                     |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)   |  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>  |  |   | 16b. Kind of Business/Industry<br><b>Restaurant</b>  |   |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>James Henry Johnson</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Frances Dorsey</b>  |  |   |  |   |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br><b>Elizabeth F. Evans - Mother</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2343 Lauretta Avenue Baltimore, MD 21223</b>  |  |   |  |   |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Vet.</b>   |  |   | Date<br><b>8/7/97</b>  |   | 20c. Location - City or Town, State<br><b>Owings Mills, MD</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>   |  |   | 22. Name and Address of Facility<br><b>Balto. MD 21214<br/>Leonard J. Ruck Inc. 5305 Harford Rd.</b>  |  |   |  |   |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. NARCOTIC INTOXICATION</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |   |  |   |  | Approximate Interval Between Onset and Death   |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |  |  |  |  |
|   |   |  |   |   |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |  |  |  |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined   |  |   | 28a. Date of Injury (Month, Day Year)<br><b>found 8/4/97</b>  |  | 28b. Time of Injury<br><b>found 1:00 PM</b> |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br><b>unknown</b>  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   | 29b. Signature and title of certifier<br>  |  |   | 29c. License number<br><b>O.C.M.E.</b>   |   |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 05, 1997</b>                                  |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Therese McKing 111 Penn Street, Baltimore, Maryland 21201</b>  |  |   |   |  |   |  |   |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  |   | 32. Registrar's Signature<br>  |  |   |  |   |  |  |  |  |





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23921

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Brooks Michael Johnson</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 05, 1997</b>  |  | 3. Time of Death<br><b>0154AM</b>  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY SHOCK TRAUMA UNIT</b>                                |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-52-6740</b>  |  | 6. Sex<br><b>1</b> M <b>2</b> F   |  | 7. Age (In yrs. last birthday)<br><b>16</b> Yrs.  |  | 8. Date of Birth<br>Month Day Year<br><b>May 17, 1981</b>  |  |
|  | 9. Birthplace (State or Foreign Country)   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director                                  | 10d. Inside City Limits<br><b>1</b> Yes <b>2</b> No  |  | 10e. Street and Number<br><b>1915 Ruxton Ave.</b>   |  | 10f. Zip Code<br><b>21216</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><b>1</b> Never Married <b>2</b> Married<br><b>3</b> Widowed <b>4</b> Divorced                                  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><b>1</b> Yes <b>2</b> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><b>1</b> Yes <b>2</b> No Specify:   |  | 14. Race - American Indian, Black, White, etc.<br><b>African American</b>  |  |
| To Be Completed by Physician/Medical Examiner                        | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>0</b> |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>   |  | 16b. Kind of Business/Industry<br><b>School</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Howard Eugene Johnson</b>  |  |
|  | 17. Mother's Name (First, Middle, Maiden Surname)<br><b>Roma Matthews</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. Roma Matthews (mother)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1915 Ruxton Ave. Balto. Md. 21216</b>   |  | 20a. Method of Disposition<br><b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State<br><b>4</b> Donation <b>5</b> Other (Specify)                   |  |
| Physician<br>/Medical<br>Examiner                                    | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Western Star</b>  |  | 20c. Date<br><b>8/9/97</b>  |  | 20d. Location - City or Town, State<br><b>Catonsville, Md.</b>  |  | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>   |  |
|  | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home<br/>2222 W. North Ave. Balto. Md. 21216</b>                       |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Gunshot Wound to Head</b><br>Due to (or as a consequence of):<br><br><b>b.</b> Due to (or as a consequence of):<br><br><b>c.</b> Due to (or as a consequence of):<br><br><b>d.</b> Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br><b>1</b> Yes <b>2</b> No <b>3</b> Probably <b>4</b> Unknown   |  | 24a. Was an autopsy performed?<br><b>1</b> Yes <b>2</b> No   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br><b>1</b> Yes <b>2</b> No                              |  | 25. Was case referred to medical examiner?<br><b>1</b> Yes <b>2</b> No  |  | 26. Place of Death (Check only one)<br>Hospital: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA Other: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)  |  | 27. Manner of Death<br><b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending investigation <b>6</b> Could not be determined |  |
|  | 28a. Date of Injury (Month, Day Year)<br><b>8/5/97</b>   |  | 28b. Time of Injury<br><b>0120 M</b>  |  | 28c. Injury at Work?<br><b>1</b> Yes <b>2</b> No  |  | 28d. Describe how injury occurred<br><b>Subject shot</b>   |  |
| State Registrar  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Street</b>                              |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Smallwood Street Baltimore</b>   |  | 29a. Certifier (Check only one)<br><b>1</b> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><b>2</b> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>Theodore H. Ferguson</b>   |  |
|  | 29c. License number<br><b>O.C.M.E.</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 05, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Heavenly McKing 111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |
| 32. Registrar's Signature<br><b>John A. Johnson</b>                  |  |  |   |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 23922

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LENORE LOUISE JENKINS

2. Date of Death

Month August

Day 6

Year 1997

3. Time of Death

1:40 A.M.

4a. Facility Name (If not institution, give street and number)

1114 Elbank Avenue

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

218-44-8191

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

52 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Nov Day 13 Year 1944

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1114 Elbank Avenue

10f. Zip Code

21239

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Case Manager

16b. Kind of Business/Industry

Social Work

17. Father's Name (First, Middle, Last)

James Jenkins

18. Mother's Name (First, Middle, Maiden Surname)

Edna Gross

19a. Informant's Name/Relationship (Type, Print)

Phylliss Arrington/Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1114 Elbank Avenue Baltimore, Maryland 21239

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Mt Calvary Cemetery

Date

8/9/97

20c. Location - City or Town, State

Baltimore County, Maryland

21. Signature of Funeral Service Licensee

Maggaleen G. Henson

22. Name and Address of Facility

Mortician Doing Business from Chatman-Harris Funeral Home, 5240 Reisterstown Road, Baltimore, Maryland 21215

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or organ failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. small cell lung cancer

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

7 months

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician2 ☐ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Mubray MD

29c. License number

RES000

29d. Date signed (Month, Day, Year)

August 7 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Smitha Subramanyam, Oncology 126, Johns Hopkins Hospital, Baltimore, MD 21287

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

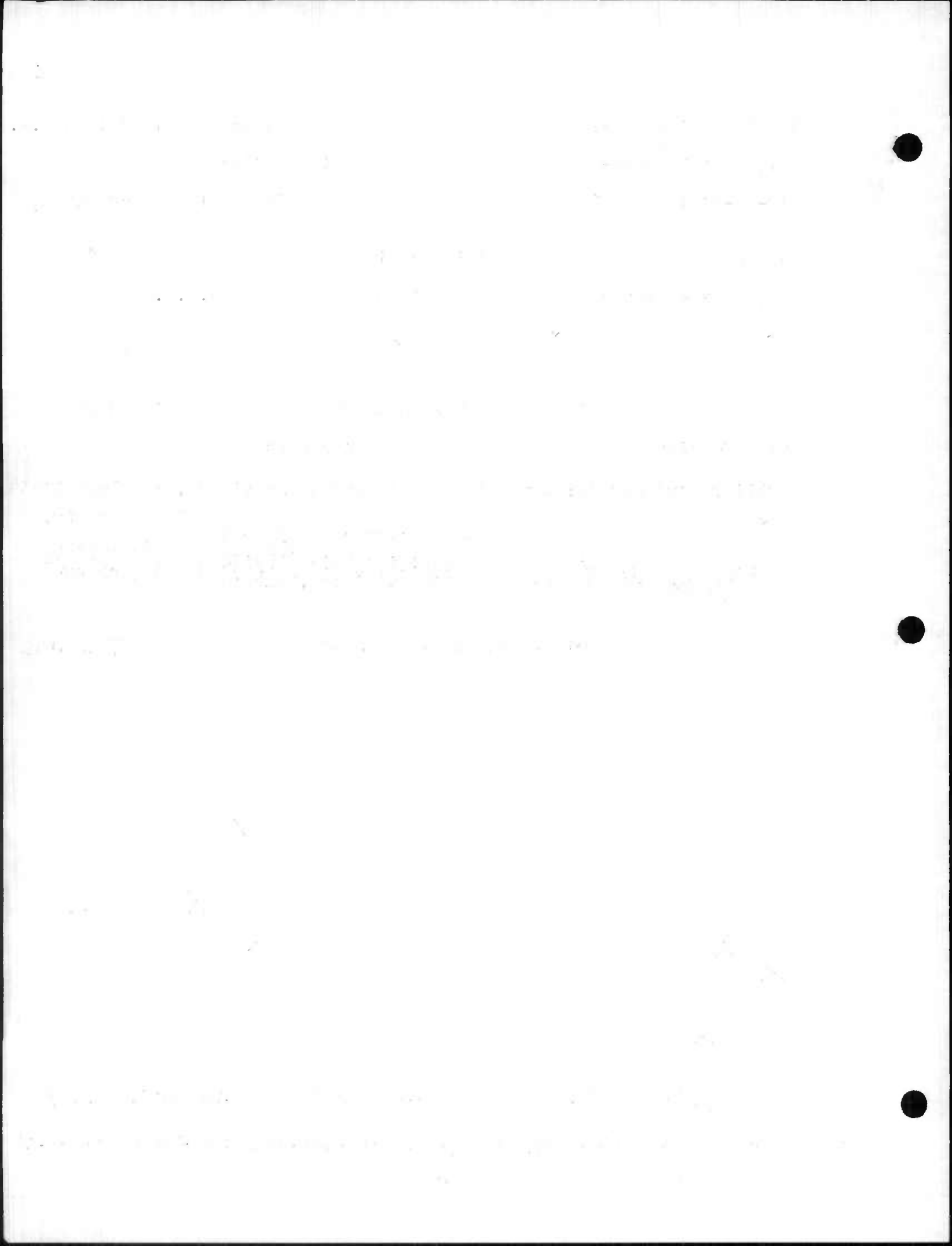
Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23923

Item 24 per PHY Film G750 8-6-97 rja

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |  |   |   |  |  |
|--|--|---|---|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><i>Johnnie E. Johnson</i>  |   |   |  | 2. Date of Death<br>Month <i>July</i> 22, Day <i>1997</i> Year   |  |   |   | 3. Time of Death<br><i>8:13 AM</i>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Johns Hopkins Bayview Medical Center</i>  |   |   |  | 4b. City, Town, or Location of Death<br><i>Baltimore City</i>  |  |   |   | 4c. County of Death<br><i>N/A</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>229-46-3842</i>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>65</i> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><i>8/17/1931</i>                                     |   | 9. Birthplace (State or Foreign Country)<br><i>Virginia</i>  |  |
|  | Usual Residence of Decedent  |   |   |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><i>Maryland</i>  |   | 10b. County<br><i>Baltimore</i>   |  | 10c. City, Town or Location<br><i>Edgemere</i>   |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  | 10e. Street and Number<br><i>8602 Oak Rd.</i>  |   |   |  | 10f. Zip Code<br><i>21219</i>  |  | 10g. Citizen of What Country?<br><i>USA</i>   |   |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <i>Korea</i>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>White</i> |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <i>9th Grade</i><br>College (1-4 or 5+) <i>Collega</i>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Steelworker</i>   |  |  |  | 16b. Kind of Business/Industry<br><i>Steel</i>  |   |  |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><i>Not Known</i>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Ethel Cecil</i>  |  |   |   |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Mrs. Edith W. Johnson Wife</i>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><i>8602 Oak Rd. Edgemere, Maryland 21219</i>  |  |   |   |  |  |
|  | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Hilltop Service Corp.</i>  |  | Data<br><i>7/25/97</i>   |  | 20c. Location - City or Town, State<br><i>Towson, Maryland</i>                              |   |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |   | 22. Name and Address of Facility<br><i>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</i>   |  |  |  |   |   |  |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <i>Congestive Heart Failure</i><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |   |   |  |  |  |   |   | Approximate Interval Between Onset and Death<br><i>Years</i>   |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |   |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |   |   |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  |  |   |   |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><i>as above</i>   |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   |   |  |  |  |   |   |  |  |
| State Registrar  | 29b. Signature and title of certifier<br><i>[Signature]</i>  |   |   |  | 29c. License number<br><i>047 299</i>  |  | 29d. Date signed (Month, Day, Year)<br><i>7/23/97</i>                                       |   |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Dr. Scott Wright, Northport Medical Center</i>  |   |   |  |  |  |   |   |  |  |
| 31. Date filed (Month, Day, Year)<br><i>AUG 06 1997</i>              |  | 32. Registrar's Signature<br><i>[Signature]</i> |   |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23924

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Richard H Karl

2. Date of Death

Month July

Day 25

Year 1997

3. Time of Death

7:39 AM

4a. Facility Name (If not institution, give street and number)

Eastpoint Nursing Home

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

214-38-1216

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

55

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

April 7, 1942

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Baltimore County

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

23 South Elwood Road

10f. Zip Code

21224

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)a. Respiratory Failure  
Due to (or as a consequence of):Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anoxic Encephalopathy

Dilated Cardiomyopathy  
Seizure disorder

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

N/A

28b. Time of Injury

N/A

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

N/A

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

N/A

28f. Location (Street and Number or Rural Route Number, City or Town, State)

N/A

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

T. Matwood MD

29c. License number

D43725

29d. Date signed (Month, Day, Year)

7/25/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

T. Matwood MD

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23925

MICHAEL A. KETCHAM

Certificate of Death

Reg. No.

|  |   |  |  |  |   |  |  |  |
|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>MICHAEL A. KETCHAM</b>   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>JULY 27 1997</b> |  | 3. Time of Death<br><b>2:39 AM</b>                         |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>DORCHESTER ST. &amp; PHILADELPHIA AVE.</b> |  |  |  | 4b. City, Town, or Location of Death<br><b>OCEAN CITY</b> |  | 4c. County of Death<br><b>WORCESTER</b>                    |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>147-76-4444</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>28</b> Yrs.          |  | 8. Date of Birth (Month, Day, Year)<br><b>OCT. 2, 1968</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>NEPTUNE, N.J.</b>  |  | 10a. State<br><b>N.J.</b>  |  | 10b. County<br><b>ESSEX</b>                               |  | 10c. City, Town or Location<br><b>BLOOMFIELD</b>           |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   | 10e. Street and Number<br><b>183 BROAD ST.</b>   |  | 10f. Zip Code<br><b>07003</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>PRESS AGENT</b>  |  | 16b. Kind of Business/Industry<br><b>COUNTY GOVERNMENT</b>   |   |  |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>GLENN KETCHAM</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>YVONNE VIGNONE KREIDEL</b>   |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>YVONNE KREIDEL</b>  |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1522 MARCOINE RD. WALL TOWNSHIP, N.J. 07719</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>ST. ANNE'S CEM.</b>   |  | Date<br><b>JULY 30 1997</b>  |   | 20c. Location - City or Town, State<br><b>GLENDOLA, N.J.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br><b>Thomas J. Spada Jr.</b>  |   | 22. Name and Address of Facility<br><b>SKANDA FH 2829 HUDSON ST. BALTIMORE, MD. 21224</b>  |  |  |   |  |  |  |
| 23a. Part I. Enter the disease or diseases that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Multiple Myeloma</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |   |  |  |  |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   |  |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |   |  |  |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  |   |  |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>SCENE</b> |  |  |   |  |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   | 28a. Date of Injury (Month, Day, Year)<br><b>7/27/97</b>   |  | 28b. Time of Injury<br><b>0239 AM</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |
|  |   | 28d. Describe how injury occurred<br><b>Subject pedaled against truck</b>  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>roadway</b>   |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Philadelphia Avenue Ocean City</b>  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><b>Therese M. King</b>  |  | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>JULY 27, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>THEODORE M KING 111 Penn Street, Baltimore, Maryland 21201</b>  |   |  |  |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |   | 32. Registrar's Signature<br><b>Gina Davidson-Randall</b>  |  |  |   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23926

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ELAINE D. KRUGER

2. Date of Death

Month

Day

Year

August 05 1997

3. Time of Death

0002

4a. Facility Name (If not institution, give street and number)

UNIVERSITY OF MARYLAND

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

213-34-3237

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58

Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

JAN. 9, 1939

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

OWINGS MILLS

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

4601 SPRINGWATER CT., APT. B

10f. Zip Code

21117

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give X

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (14 or 5+)

18a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

MEDICAL RECEPTIONIST

16b. Kind of Business/Industry

MEDICINE

17. Father's Name (First, Middle, Last)

ROBERT

JOHN

PACHINO

18. Mother's Name (First, Middle, Maiden Surname)

ESTHER

HARRIS

19a. Informant's Name/Relationship (Type, Print)

HERBERT C. KRUGER (HUS.)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4601 SPRINGWATER CT., APT. B OWINGS MILLS, MD 21117

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MD FREE STATE POST JWV

Date

8/6/97

20c. Location - City or Town, State

ROSEDALE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 REISTERSTOWN RD., PIKESVILLE, MD 21208

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

a. PULMONARY HYPERTENSION

12-24 hours

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. CONGESTIVE HEART FAILURE

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus

Coronary Artery Disease

End-Stage Renal Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

Inpatient

2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending  
Investigation6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

D. Stewart

29c. License number

P10249

29d. Date signed (Month, Day, Year)

AUG. 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DYLAN Stewart M.D. UNIVERSITY OF MARYLAND

31. Date filed (Month, Day, Year)

AUG 07 1997

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23927  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Carmen L. Kruse

2. Date of Death

Month  
AugustDay  
4Year  
1997

3. Time of Death

17:45

4a. Facility Name (If not institution, give street and number)

Johns Hopkins Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Funeral  
Director

5. Social Security Number

306-42-0218

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

58 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
March 2, 1939

9. Birthplace (State or Foreign Country)

Indiana

Usual Residence of Decedent

10a. State

Georgia

10b. County

Gwinnett

10c. City, Town or Location

Suwanee

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1110 Swan Mill Ct.

10f. Zip Code

30024

10g. Citizen of What Country?

United States

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

3 years

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Manager Advertising

16b. Kind of Business/Industry

Communications

17. Father's Name (First, Middle, Last)

Raymond Kruse

18. Mother's Name (First, Middle, Maiden Surname)

Ruth Keel

19a. Informant's Name/Relationship (Type, Print)

Mrs. Elaine W. Lyon / Sister

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

14276 Sedwick Ave. P.O. Box 31, Solomons, MD 20688

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Hilltop Service Corp.

Date

August 6, 1997

20c. Location - City or Town, State

Towson, Maryland

21. Signature of Funeral Service Licensee

Michael E. Canapp

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Rd., Baltimore, MD 21214

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Pneumonia

Due to (or as a consequence of):

5 days

Sequitely list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Pulmonary Embolus

Due to (or as a consequence of):

5 days

c. Metastatic Breast Cancer

Due to (or as a consequence of):

2 months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
Investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Julie R. Brahmer, MD

29c. License number

D0051770

29d. Date signed (Month, Day, Year)

August 5 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Julie R. Brahmer Johns Hopkins Hospital

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson Handell

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 23a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that this death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detachable and use as the burial-transit  
10

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23928

## Certificate of Death

Reg. No.

|  |  |   |   |  |  |   |  |                                   |  |
|--|--|---|---|--|--|---|--|-----------------------------------|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Susannah Lampley</b>  |   |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>02</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>2:20 PM</b>   |                                   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Manorcare Nursing Ctr. Ruxton</b>   |   |   |  | 4b. City, Town, or Location of Death<br><b>Towson</b>  |   | 4c. County of Death<br><b>Baltimore</b>  |                                   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>260-36-3744</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>81</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 16, 1916</b>  |                                   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Canada</b>  |   |   |  |  |   |  |                                   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>  |   | 10c. City, Town or Location<br><b>Dundalk</b>  |                                   |  |
|  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |  |   |  |                                   |  |
|  | 10e. Street and Number<br><b>7927 St. Monica Drive</b>   |   | 10f. Zip Code<br><b>21222</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |   |  |                                   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |                                   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9 Years</b>  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Sales Clerk</b>                       |  | 16b. Kind of Business/Industry<br><b>Retail</b>  |   |  |                                   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Joseph Patrick White</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Margaret Mackey</b>   |  |  |   |  |                                   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary Cotherman/Daughter</b>   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7927 St. Monica Drive Dundalk, Maryland 21222</b> |  |  |   |  |                                   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Meadowridge Mem. Pk. Cem.</b>  |  | Date<br><b>8/6/97</b>  |   | 20c. Location - City or Town, State<br><b>Elkridge, Maryland</b>   |                                   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Ratnik M. Fleming</b>  |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>                         |  |  |   |  |                                   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><br>a. <b>Alzheimer</b><br>Due to (or as a consequence of):<br>b. <b>Dehydration</b><br>Due to (or as a consequence of):<br>c. <b>Hypertension</b><br>Due to (or as a consequence of):<br>d. <b>Anemia</b> |   | Approximate Interval Between Onset and Death<br><br><b>&gt; 3 years</b><br><b>&gt; 1 Month</b><br><b>&gt; 3 years</b><br><b>&gt; 3 years</b>          |  |  |   |  |                                   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |                                   |  |
|  |  |   |   |  |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                   |  |
|  |  |   |   |  |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                                   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |   |  |                                   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>John L. Dell</b>  |   | 29c. License number<br><b>142736</b>             |  | 29d. Date signed (Month, Day, Year)<br><b>8-3-97</b>  |  |                                   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Manorcare N.H. Charles Street Towson</b>  |  |   |   |  |  |   |  |                                   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |   |  |  |   |  |                                   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





97-4200-510

CMK

JOSEPH MACHIN

Items: 23a part I, 27 per MEO G-751 9/24/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23929

## Certificate of Death

Reg. No.

Physician  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Earl Machin IV

2. Date of Death

Month Day Year  
JULY 28, 1997

3. Time of Death

1000AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

218-70-9554

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 16, 1971

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Sparks

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16214 A Yeoho Road

10f. Zip Code

21152

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Environmental Engineer

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

Joseph E. Machin, III

18. Mother's Name (First, Middle, Maiden Surname)

Joyce M. Marshall

19a. Informant's Name/Relationship (Type, Print)

Joyce M. Quintavalle/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17326 Bushland Rd., Parkton, MD 21120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pine Grove United Methodist Cemetery

Date

Aug. 2, 1997

20c. Location - City or Town, State

Parkton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.  
24 Second St., New Freedom, PA 17349

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

State  
Registrar

97-4200-510

CMK

JOSEPH MACHIN

Items: 23a part I, 27 per MEO G-751 9/24/97 dh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23929

## Certificate of Death

Reg. No.

Physician  
Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Joseph Earl Machin IV

2. Date of Death

Month Day Year  
JULY 28, 1997

3. Time of Death

1000AM

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS HOSPITAL E.R.

4b. City, Town, or Location of Death

BALTIMORE CITY

4c. County of Death

5. Social Security Number

218-70-9554

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

26

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 16, 1971

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD

10b. County

Baltimore

10c. City, Town or Location

Sparks

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16214 A Yeoho Road

10f. Zip Code

21152

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

5 College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Environmental Engineer

16b. Kind of Business/Industry

Engineering

17. Father's Name (First, Middle, Last)

Joseph E. Machin, III

18. Mother's Name (First, Middle, Maiden Surname)

Joyce M. Marshall

19a. Informant's Name/Relationship (Type, Print)

Joyce M. Quintavalle/Mother

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

17326 Bushland Rd., Parkton, MD 21120

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Pine Grove United Methodist Cemetery

Date

Aug. 2, 1997

20c. Location - City or Town, State

Parkton, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

J.J. Hartenstein Mortuary, Inc.  
24 Second St., New Freedom, PA 17349

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARDIAC ARRHYTHMIA

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

JULY 29, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23930

Reg. No.

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Angel Maio</b>  |   | 2. Date of Death<br>Month <b>August</b> Day <b>2</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:33 AM</b>                    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Franklin Square Hospital Center</b> |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>   |  | 4c. County of Death<br><b>Baltimore</b>               |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-98-5117</b>  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>16</b> Yrs.  | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.                        |
|   | 8. Date of Birth (Month, Day, Year)<br><b>7/05/81</b>  |   | 9. Birthplace (State or Foreign Country)<br><b>Baltimore, Md.</b>   |  |   |
| Usual Residence of Decedent   |  |   |   |  |   |
| 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore Co.</b>   |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |   |  |   |
| 10e. Street and Number<br><b>4300 Bedrock Circle #202</b>   |  |   | 10f. Zip Code<br><b>21236</b>   |  | 10g. Citizen of What Country?<br><b>United States</b> |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |   |   |  |   |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Student</b>                       |   | 16b. Kind of Business/Industry<br><b>High School</b>   |   |
| 17. Father's Name (First, Middle, Last)<br><b>Giuseppe Maio</b>   |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Brenda Lee Sexton</b>   |  |   |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Rodney Reamer (Step-Father)</b>  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4300 Bedrock Circle #202 Baltimore, Md. 21236</b> |  |   |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Dulaney Valley Mem. Gard.</b>  |   | 20c. Location - City or Town, State<br><b>8/05/97 Timonium, Maryland</b>   |   |
| 21. Signature of Funeral Service Licensee<br><b>Jeffrey L. Gair</b>   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, Md. 21204</b>                                     |   |  |   |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Multiple traumatic injuries incurred as passenger in motor vehicle accident immediate</b>   |  |   |   |  |   |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  |   |   |  |   |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |   |  |   |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |   |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |   |  |   |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |   |   |  |   |
| 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |   |  |   |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)<br><b>August 2, 1997</b>   |   | 28b. Time of Injury<br><b>0015 AM</b>  |   |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred<br><b>Passenger in MVA</b>  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>STREET</b>  |   |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |   |  |   |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |   |  |   |
| 29b. Signature and title of certifier<br><b>J. Crossan Donovan, M.D.</b>  |  | 29c. License number<br><b>DO7632</b>  |   | 29d. Date signed (Month, Day, Year)<br><b>August 4, 1997</b>   |   |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. Crossan Donovan, M.D. 2112 DUNDALK AVE., BALTO MD 21222</b>   |  |   |   |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  |   |   |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or item 23a or 23a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

2

State  
Registrar

Bartholomew, John  
1871-1872

Bartholomew, John  
1871-1872

Bartholomew, John  
1871-1872

Bartholomew, John  
1871-1872

97 23931

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |  |   |  |   |  |   |  |   |  |   |  |
|---|--|--|--|---|--|---|--|---|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br>James Allen Moore   |  |  |  | 2. DATE OF DEATH<br>JULY 31, 1997   |  |   |  | 3. TIME OF DEATH<br>7:30 P M  |  |   |  |   |  |   |  |
| 4. SOCIAL SECURITY NUMBER<br>119-03-0356  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br>83 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS  |  | IF UNDER 24 HRS.<br>HOURS MIN.  |  | 7. DATE OF BIRTH<br>Sept. 30, 1913                      |  | 8. BIRTHPLACE (State or Foreign Country)<br>Stamford, Texas   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br>Greater Baltimore Medical Center  |  |  |  |   |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br>Towson   |  |   |  | 9c. COUNTY OF DEATH<br>Baltimore Co.                    |  |   |  |   |  |
| 10a. STATE<br>Maryland  |  |  |  | 10b. COUNTY<br>Baltimore Co.  |  |   |  | 10c. CITY, TOWN OR LOCATION<br>Glen Arm   |  |   |  | 10d. INSIDE CITY LIMITS?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO       |  |   |  |
| 10e. STREET AND NUMBER<br>11630 Glenarm Road  |  |  |  |   |  | 10f. ZIP CODE<br>21057  |  |   |  | 10g. CITIZEN OF WHAT COUNTRY?<br>United States          |  |   |  |   |  |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:   |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: White                                |  |   |  |   |  |   |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+) 06   |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br>Chemical Engineer  |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br>Sugar Industry<br>Amstar Corp.                                |  |   |  |   |  |   |  |
| 17. FATHER'S NAME (First, Middle, Last)<br>Allen Letcher Moore  |  |  |  |   |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br>LuLa Ella Jones  |  |   |  |   |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br>Clarke Langrall, Jr. (Step-Son)   |  |  |  |   |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>Suite 202 204 East Joppa Rd. Towson, Md. 21286 |  |   |  |   |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br>Druid Ridge Cemetery 8/04/97   |  |   |  | 20c. LOCATION — City or Town, State<br>Baltimore, Maryland                                      |  |   |  |   |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br>Jeffrey L. Gair  |  |  |  |   |  | 22. NAME AND ADDRESS OF FACILITY<br>Ruck Towson Funeral Home,<br>1050 York Rd. Towson, Md.  |  |   |  |   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio-Respiratory Failure<br>Due to (or as a consequence of):<br>b. Sub Dural Hematoma<br>Due to (or as a consequence of):<br>c. Fracture of Hip<br>Due to (or as a consequence of):<br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |   |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  |   |  |   |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>   |  |  |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO   |  |  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide   |  |  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)<br>7/25/97  |  | 28b. TIME OF INJURY<br>11 P M   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED<br>Fell on floor Room |  |   |  |   |  |
| 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)<br>At Home care Living   |  |  |  | 28f. LOCATION (Street and Number or Rural Route Number)<br>111 Hamlet Hill Rd Baltimore   |  |   |  |   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |  |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br>Charles F. O'Donnell MD  |  |  |  |   |  | 29c. LICENSE NUMBER<br>D-07383  |  |   |  | 29d. DATE SIGNED (Month, Day, Year)<br>August 1, 1997   |  |   |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)<br>Charles F. O'Donnell MD - 111 Hamlet Hill Rd Baltimore  |  |  |  |   |  |   |  |   |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br>AUG 07 1997  |  |  |  | 32. JUDGE'S SIGNATURE (Type/Print)<br>[Signature]   |  |   |  |   |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 6876 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |  |   |
|--|--|--|--|---|--|--|---|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>SAMUEL MORRIS MERWITZ</b>   |  |  |  | 2. DATE OF DEATH<br>MONTH <b>AUG</b> DAY <b>4</b> YEAR <b>1997</b>  |  | 3. TIME OF DEATH<br><b>9:40AM</b>  |   |
| 4. SOCIAL SECURITY NUMBER<br><b>215-22-9504</b>  |  | 5. SEX<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>73</b> YRS.  |  | 7. DATE OF BIRTH<br>MONTH <b>JAN</b> DAY <b>8</b> YEAR <b>1924</b>                   |   |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>HEBREW HOME OF GREATER WASHINGTON</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Rockville</b>   |  | 9c. COUNTY OF DEATH<br><b>Montgomery</b>   |   |
| 10a. STATE<br><b>MARYLAND</b>  |  |  |  | 10b. COUNTY<br><b>MONTGOMERY</b>  |  | 10c. CITY, TOWN OR LOCATION<br><b>SILVER SPRING</b>                                  |   |
| 10d. INSIDE CITY LIMITS?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| 10e. STREET AND NUMBER<br><b>1701 FRANWALL AVE.</b>  |  |  |  | 10f. ZIP CODE<br><b>20902</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   |
| 11. MARITAL STATUS<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES?<br>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES <b>WWII</b>  |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: |  | 14. RACE — American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>              |   |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>CPA</b>   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>U.S. GOVERNMENT</b>                             |   |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>ISRAEL MERWITZ</b>   |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>ROSE ROSENBERG</b>  |  |  |   |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>MRS. MARILYN MERWITZ (WIFE)</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1701 FRANWALL AVE. SILVER SPRING, MD 20902</b>  |  |  |   |
| 20a. METHOD OF DISPOSITION<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, hospital, or other place)<br><b>MIRRO KODESH BETH ISRAEL</b>   |  | DATE<br><b>8-5-1997</b>   |  | 20c. LOCATION — City or Town, State<br><b>BALTIMORE, MD</b>                          |   |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Ellen Lippson</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>SOL LEVINSON &amp; BROS., INC.<br/>8900 Reisterstown Rd Pikesville, MD 21208</b>   |  |  |   |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>BRAIN STEM INFARCT</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>b. <b>CEREBROVASCULAR DISEASE</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>YEARS</b><br>c. <b>HYPERTENSION</b><br>DUE TO (OR AS A CONSEQUENCE OF): <b>YEARS</b><br>d.<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST |  |  |  |   |  |  | Approximate Interval Between Onset and Death  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PERIPHERAL VASCULAR DISEASE</b>   |  |  |  |   |  |  | 24a. WAS AN AUTOPSY PERFORMED?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO  |  |  |  |   |  |  |   |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>  |  |  |  |   |  |  |   |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA<br>OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |   |  |  |   |
| 27. MANNER OF DEATH<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide  |  | 28a. DATE OF INJURY (Month, Day, Year)   |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO |   |
| 28d. DESCRIBE HOW INJURY OCCURRED  |  |  |  | 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |
| 29a. CERTIFIER (Check only one)<br>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |  |   |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Steven Lippson MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D 05885</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>8/4/97</b>                                 |   |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>STEVEN LIPSON 6121 MONTROSE RD, ROCKVILLE</b>  |  |  |  |   |  |  |   |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |  |  | 32. REGISTRAR'S SIGNATURE<br><i>John Davidson-Randall</i>   |  |  |   |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

E





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23933

Item 17 8-7-97 Film G750 W.H.Per F/H

## Certificate of Death

Reg. No.

|   |   |  |  |   |   |  |   |  |
|---|---|--|--|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>MIRIAM K. MACKS</b>  |  |  |   | 2. Date of Death<br>Month <b>August</b> Day <b>3</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1920 hrs</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>NORTHWEST HOSPITAL</b>   |  |  |   | 4b. City, Town, or Location of Death<br><b>RANDALLSTOWN</b>   |  | 4c. County of Death<br><b>BALTIMORE</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>218-52-1795</b>   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>87</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>AUG. 20, 1909</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>  |   | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE</b>   |  |
| To Be Completed by Funeral Director   | Usual Residence of Decedent<br>10a. State <b>MARYLAND</b> 10b. County <b>BALTIMORE</b> 10c. City, Town or Location <b>BALTIMORE</b> 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No          |  |  |   | 10e. Street and Number<br><b>3506 JO ANN DRIVE</b>  |  | 10f. Zip Code<br><b>21244</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
|   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)                          |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>SECRETARY</b>   |  |  |   | 16b. Kind of Business/Industry<br><b>UNITED STATES ARMY</b>   |  |   |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>ABRAHAM KRAVETZ</b>   |  |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>REBECCA GOCHRACH</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>MR. GERALD MACKS (SON)</b>   |  |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3203 NORTHBROOK ROAD BALTIMORE, MD 21208</b>  |  |   |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) |  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>BALTIMORE HEBREW</b>   |  |   |  |
|   | 20c. Location - City or Town, State<br><b>8-5-1997- REISTERSTOWN, MD</b>  |  |  |   | 21. Signature of Funeral Service Licensee<br>   |  |   |  |
|   | 22. Name and Address of Facility<br><b>SOL LEVINSON &amp; BROS., INC.</b><br><b>8900 Reisterstown Rd Pikesville, MD 21208</b>   |  |  |   | 23a. Pert 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. METASTATIC LIVER CARCINOMA</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  |   |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |  |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |  |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |   |  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined   |   |  |   |  |
| 28a. Date of Injury (Month, Day, Year)<br><b>28b. Time of Injury</b><br><b>M</b>  |   |  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |  |   |  |
| 28d. Describe how injury occurred   |   |  |  | 28e. Place of Injury - At home, farm, street, tectory, office building, etc. (Specify)  |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |  |   |  |
| 29b. Signature and title of certifier<br>   |   |  |  | 29c. License number<br><b>D37333</b>  |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>AUGUST 3 1997</b>   |   |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>C. NAVI MD, NHC, BALTO. MD 21133</b>   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |   |  |  | 32. Registrar's Signature<br>   |   |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial/transit permit.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23934

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Ronald Melin

2. Date of Death

Month Day Year  
JULY 24 1997

3. Time of Death

11:45 AM

4a. Facility Name (If not institution, give street and number)

Deaton University of Maryland Medicine

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore City

Funeral  
Director

5. Social Security Number

220-42-4368

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

63

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Sept. 9, 1933

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

unknown

10b. County

unknown

10c. City, Town or Location

unknown

10d. Inside City Limits

1 ☐ Yes 2 ☐ No

10e. Street and Number

unknown

10f. Zip Code

unknown

10g. Citizen of What Country?

unknown

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:

unknown

13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (1-4 or 5+)

unknown

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☒ Other (Specify) in state20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

State Anatomy Board Ronald S. Wade State Anatomy Board 655 W. Baltimore St  
Baltimore, Maryland 2120123a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)e. pneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

1 wk

b. sepsis  
Due to (or as a consequence of):

1 wk

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastc. Anoxic encephalopathy  
Due to (or as a consequence of):

1 year

d. Resp failure vent dependent

"

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

D 30444

29d. Date signed (Month, Day, Year)

7/25/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dmc  
611 South Charles Street Baltimore MD 21201

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

*[Signature]*

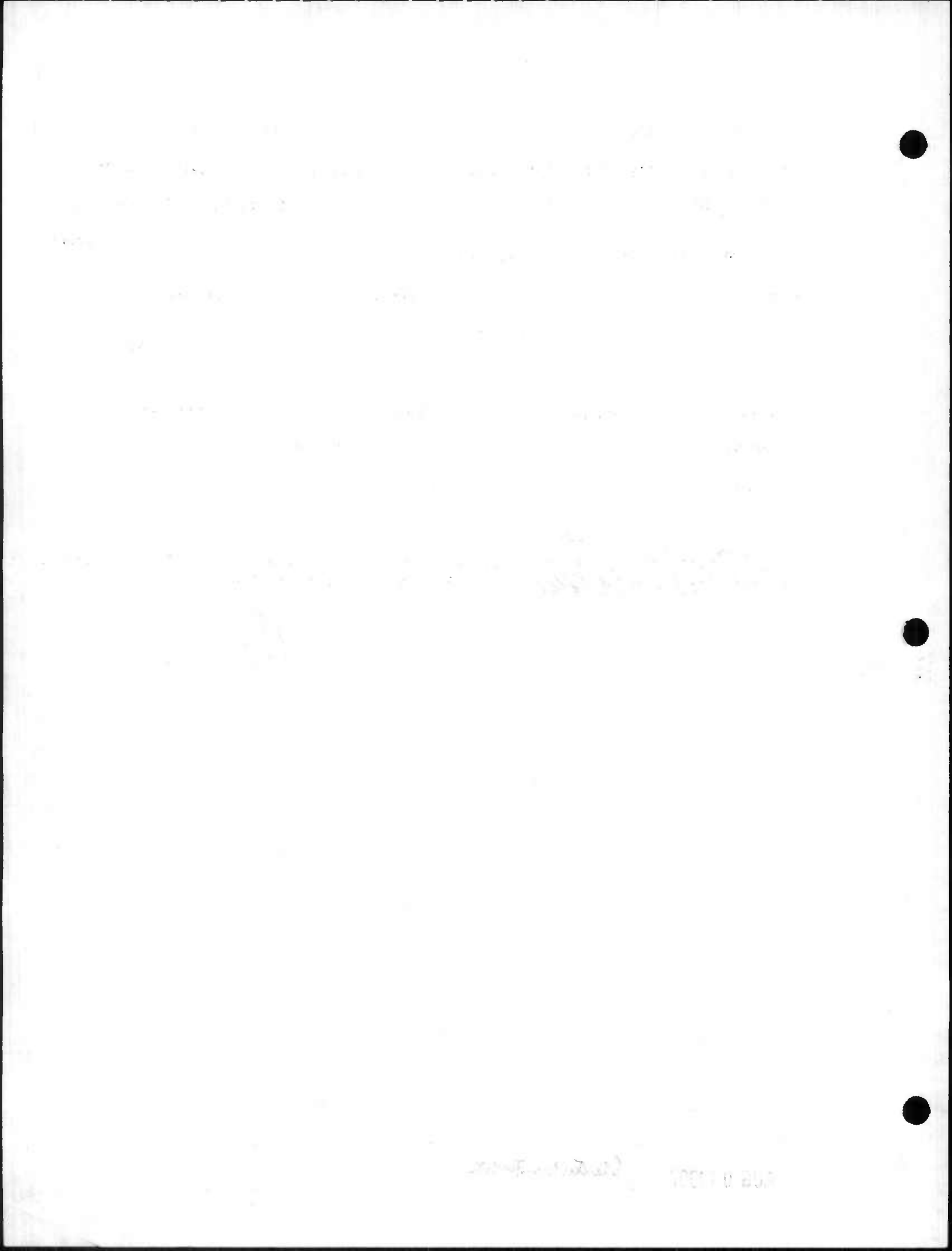
Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transitState  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23935

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Robert Marion Madaris

2. Date of Death

August 2, 1997

3. Time of Death

11:59 pm

4a. Facility Name (If not institution, give street and number)

2179 Fawn Court

4b. City, Town, or Location of Death

Waldorf

4c. County of Death

Charles

Funeral  
Director

5. Social Security Number

229-32-7746

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

66

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Nov 10, 1930

9. Birthplace (State or Foreign Country)

S.C. Carolina

Usual Residence of Decedent

10a. State

Maryland

10b. County

Charles

10c. City, Town or Location

Waldorf

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2179 Fawn Ct.

10f. Zip Code

20601

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Contracts Admin.

16b. Kind of Business/Industry

McDonnell-Douglas

17. Father's Name (First, Middle, Last)

John D Madaris

18. Mother's Name (First, Middle, Maiden Surname)

Sally Gunter

19a. Informant's Name/Relationship (Type, Print)

Patricia Ann Madaris

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2179 Fawn Ct Waldorf, MD 20601

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Mt Comfort Cemetery

Date

8/6/97

20c. Location - City or Town, State

Alex. VA

21. Signature of Funeral Service Licensee

E. J. Kloss

22. Name and Address of Facility

Everly-Wheatley Funeral Home  
1500 W Braddock Rd. Alex. VA23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Approximate  
Interval Between  
Onset and DeathImmediate Cause (Final  
disease or condition  
resulting in death)

e. Bone Cancer

Due to (or as a consequence of):

f. POEM SYNDROME

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide  
4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

29b. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Dr. Krishan Mathur

29c. License number

D28352

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Dr. Krishan Mathur, P. O. Box 2729, La Plata, MD 20646

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson Randall

Baltimore, Maryland 21215-0020

permitted. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23936

ITEM: 25 PER DR. G-750 8-7-97 eoh

## Certificate of Death

Reg. No.

|   |   |  |  |   |  |  |  |   |  |
|---|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALBERT Y NYREN</b>                                       |  |  |   | 2. Date of Death<br>Month Day Year<br><b>AUG 04 1997</b> |  | 3. Time of Death<br><b>1835</b>  |   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>HOWARD COUNTY GENERAL HOSPITAL</b> |  |  |   | 4b. City, Town, or Location of Death<br><b>COLUMBIA</b>  |  | 4c. County of Death<br><b>HOWARD</b>   |   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>022-14-4505</b>   |  | 8. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br>Yrs. <b>77</b>         |  | 6. Data of Birth (Month, Day, Year)<br><b>NOV. 29, 1919</b>                                    |   |  |
|   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>HOWARD</b>   |   | 10c. City, Town or Location<br><b>COLUMBIA</b>           |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   |  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1943-1945</b>  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <input type="checkbox"/> Collage (1-4or 5+) <input checked="" type="checkbox"/> <b>4</b>   |   |  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOREIGN SERVICE OFFICER</b>   |  | 16b. Kind of Business/Industry<br><b>U.S. STATE DEPARTMENT</b>   |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>OLAF NYREN</b>  |   |  |  | 18. Mother's Name (First, Middle, Maiden Summa)<br><b>MABEL LONGFELLOW</b>  |  |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>GENEVIEVE E. NYREN</b>   |   |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5254 ELIOTS OAK ROAD COLUMBIA MARYLAND 21044</b>  |  |  |  |   |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |   |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MD VA CEM GARRISON FOREST</b>  |  | 20c. Location - City or Town, State<br><b>8/8/1997 OWINGS MILL MARYLAND</b>  |  |   |  |
| 21. Signature of Funeral Service Licensee<br>   |   |  |  | 22. Name and Address of Facility<br><b>WITZKE FUNERAL HOME, INC. OF COLUMBIA</b><br><b>5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045</b>  |  |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. INTRACEREBRAL HEMORRHAGE</b><br>Due to (or as a consequence of):<br><b>b. ATRIAL FIBRILLATION</b><br>Due to (or as a consequence of):<br><b>c.</b><br>Due to (or as a consequence of):<br><b>d.</b> |   |  |  | Approximate Interval Between Onset and Death<br><b>1-2 DAYS</b><br><b>WEEKS</b>   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |  |  |   |  |
|   |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accidental <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |   |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   |   |  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |  | 29b. Signature and title of certifier<br>  |  |  |  | 29c. License number<br><b>D42892</b>  |  |
|   |   |  |  | 29d. Date signed (Month, Day, Year)<br><b>AUG. 04 1997</b>  |  |  |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>FRANCIS CHUIDIAN 10724 LITTLE PATUXENT PKWY STE 200 MD 21044</b>   |   |  |  | 31. Data filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  |  |  | 32. Registrar's Signature<br>                        |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23937

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

GERSH NUDELMAN

2. Date of Death

Month Day Year  
AUGUST 4, 1997

3. Time of Death

3:50pm

4a. Facility Name (If not institution, give street and number)

LORIEN NURSING HOME

4b. City, Town, or Location of Death

COLUMBIA

4c. County of Death

HOWARD

5. Social Security Number

219-90-5288

6. Sex

☒ M ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
APR. 13, 1911

9. Birthplace (State or Foreign Country)

ROMANIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

HOWARD

10c. City, Town or Location

COLUMBIA

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

7080 CRADLEROCK WAY

10f. Zip Code

21045

10g. Citizen of What Country?

ROMANIA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
8

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

MILL WORKER

16b. Kind of Business/Industry

ALUMINUM PRODUCTS

17. Father's Name (First, Middle, Last)

YANKEL

18. Mother's Name (First, Middle, Maiden Surname)

MENY

UNKNOWN

19a. Informant's Name/Relationship (Type, Print)

MRS. LIZA NUDELMAN (WIFE)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7080 CRADLEROCK WAY COLUMBIA, MD 21045

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

CHEVRA AHAVAS CHESED 8-6-1997-

Date

20c. Location - City or Town, State

RANDALLSTOWN, MD

21. Signature of Funeral Service Licensee

William Levinson

22. Name and Address of Facility

SOL LEVINSON & BROS., INC.  
8900 Reisterstown Rd Pikesville, MD 21208

23a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF THE COLON

2 years

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

William Flowers MD

29c. License number

D20789

29d. Date signed (Month, Day, Year)

August 5, 1997.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

William Flowers MD 11055 Little Patuxent Columbia MD

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Signature of Registrar

John R. ...

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

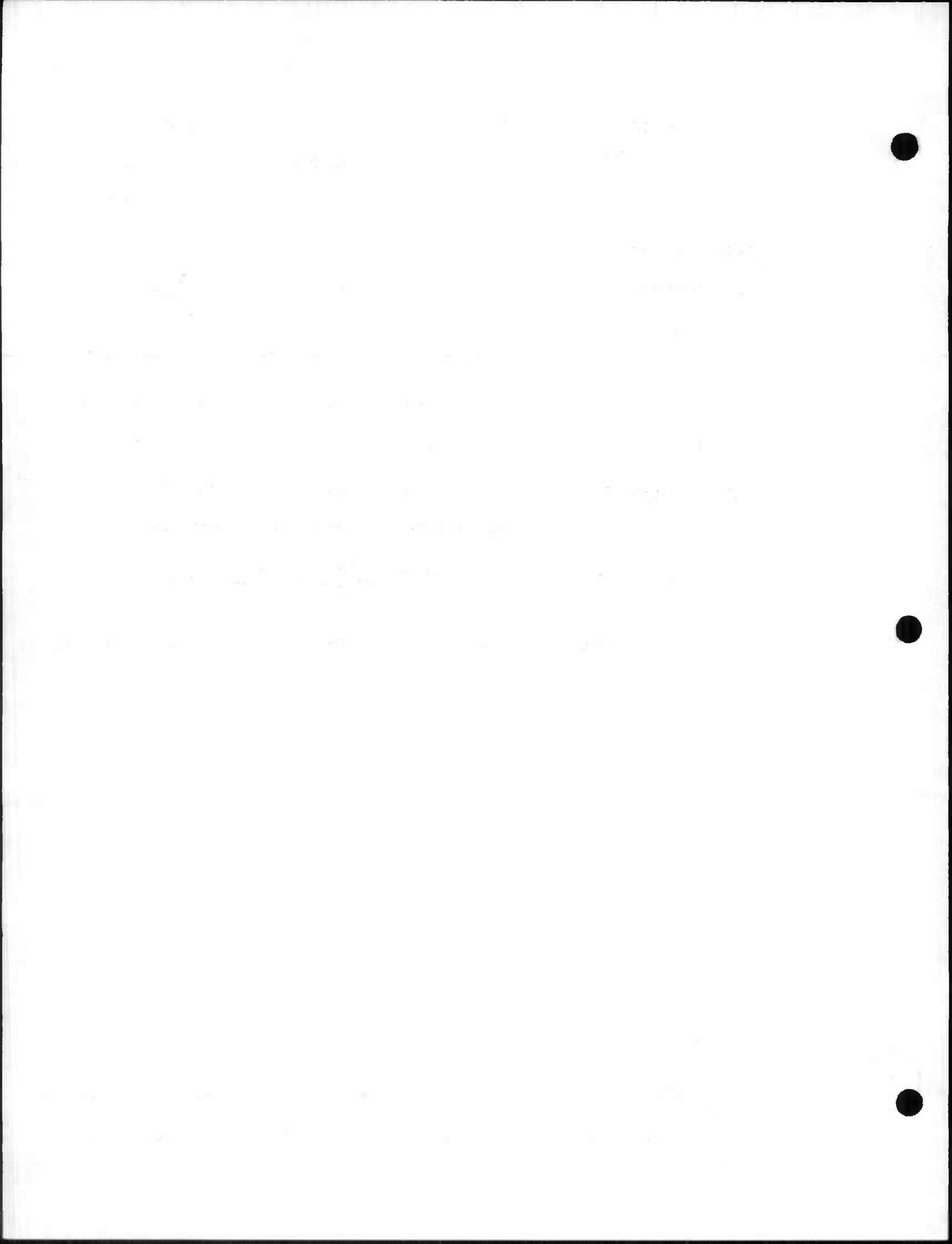
Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the hospital or attending physician: The law requires that the death certificate be executed within 24 hours after death. To the funeral director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23938

Item 19a 8-7-97 Film G750 W.H.Per F/H

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elmer M. Newhouse

2. Date of Death

August 4 1997

3. Time of Death

7:15 AM

4a. Facility Name (If not institution, give street and number)

University of Maryland Medical System

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

5. Social Security Number

217-07-2401

6. Sex

XX M 20 F

7. Age (In yrs. last birthday)

81 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

JUNE 23, 1916

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State  
MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

10 Yes 20 No

10e. Street and Number

3011 FALLSTAFF RD., APT. 507

10f. Zip Code

21209

10g. Citizen of What Country?

USA

11. Marital Status

10 Never Married 20 Married

30 Widowed 40 Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

10 Yes 20 No

If Yes, Give

Year or Dates:

WWII

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

10 Yes 20 No Specify:

14. Race - American Indian,

Black, White, etc.

Specify:

WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

ATTORNEY

16b. Kind of Business/Industry

AT LAW

17. Father's Name (First, Middle, Last)

ABRAHAM

NEWHOUSE

18. Mother's Name (First, Middle, Maiden Surname)

ANNA

SACHS

19a. Informant's Name/Relationship (Type, Print)

MRS. SUSAN N. HOCHBERG (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5110 SPRINGLAKE WAY BALTIMORE, MD 21212

20a. Method of Disposition

10 Burial 20 Cremation 30 Removal from State

40 Donation 50 Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

MIKRO KODESH BETH ISRAEL 8-6-1997 BALTIMORE, MD

21. Signature of Funeral Service Licensee

Gallensue Levinson

22. Name and Address of Facility

SOL LEVINSON &amp; BROS., INC.

8900 Reisterstown Rd Pikesville, MD 21208

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)

a.

Respiratory Arrest

Due to (or as a consequence of):

b.

Congestive Heart Failure

Due to (or as a consequence of):

c.

Atrial Fibrillation

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

5-10 min

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Congestive Heart Failure

Gouty Arthritis

23b. Did tobacco use contribute to the cause of death?

10 Yes 20 No 30 Probably 40 Unknown

24a. Was an autopsy  
performed?

10 Yes 20 No

24b. Were autopsy findings  
available prior to  
completion of causa  
of death?

10 Yes 20 No

25. Was case referred to medical  
examiner?

10 Yes 20 No

Hospital:

10 Inpatient

20 ER/Outpatient

30 DOA

Other:

40 Nursing Home

50 Residence

60 Other (Specify)

27. Manner of Death

10 Natural

20 Accident

30 Suicide

40 Homicide

50 Pending

Investigation

60 Could not be

determined

28a. Date of Injury

(Month, Day Year)

28b. Time of

Injury

28c. Injury at

Work?

10 Yes 20 No

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

20 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Robert L. Rogers M.D.

29c. License number

9324

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

Robert L. Rogers, M.D. 22 S. Greenest. Baltimore, MD 21201

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

The Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

THE UNIVERSITY OF CHICAGO

DEPARTMENT OF CHEMISTRY

RECEIVED

APR 10 1964

FROM

DR. J. H. GOLDSTEIN

TO

DR. R. M. MAYER

RE

RECEIVED

APR 10 1964

FROM

DR. J. H. GOLDSTEIN

TO

DR. R. M. MAYER

RE

RECEIVED

APR 10 1964

FROM

DR. J. H. GOLDSTEIN

TO

DR. R. M. MAYER

RE

RECEIVED

APR 10 1964

FROM

DR. J. H. GOLDSTEIN

TO

DR. R. M. MAYER

RE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23939

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

George M. Nomick, Jr.

2. Date of Death

August 2 1997

3. Time of Death

6:15 PM

4a. Facility Name (If not institution, give street and number)

10064 Whitworth Way

4b. City, Town, or Location of Death

Ellicott City

4c. County of Death

Howard

Funeral  
Director

5. Social Security Number

212-28-9075

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 21, 1931

9. Birthplace (State or Foreign Country)

West Virginia

Usual Residence of Decedent

10a. State

Maryland

10b. County

Howard

10c. City, Town or Location

Ellicott City

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

10064 Whitworth Way

10f. Zip Code

21042

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No -  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Store Owner

16b. Kind of Business/Industry

Peppridge Farm Bakery

17. Father's Name (First, Middle, Last)

George M. Nomick, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Myrtle Smoot

19a. Informant's Name/Relationship (Type, Print)

Margaret G. Nomick (Wife)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

10064 Whitworth Way Ellicott City, Maryland 21042

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Meadowridge Memorial Park

Date

Aug. 6,

1997

20c. Location - City or Town, State

Dorsey, Maryland

21. Signature of Funeral Service Licensee

Robert L. Bueh

22. Name and Address of Facility

Witzke Funeral Home of Catonsville, Inc.

1630 Edmondson Avenue Catonsville, Maryland 21228

23a. Part I. Enter the disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. metastatic prostate cancer

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

7 years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

N/A

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

28. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury et  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Robert L. Bueh

29c. License number

D41139

29d. Date signed (Month, Day, Year)

Aug 4<sup>th</sup>, 97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

CLEMENT B. KNIGHT MD 11065 LITTLE PATUXENT PKWY.  
COLUMBIA, MD. 21044

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerDivision of Vital Records, P.O. Box 68760,  
The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23940

Items: 23a part I, II, 27 per MEO G-750 8/11/97 dh  
HARRY POWELL

Certificate of Death

Reg. No.

|  |  |   |   |  |   |  |  |  |
|--|--|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Harry T. Powell</b>                       |   |   |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 03 1997</b> |  | 3. Time of Death<br><b>10:55 AM</b>  |  |
|  | 4e. Facility Name (If not institution, give street and number)<br><b>CHURCH HOSPITAL</b> |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>    |  | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>219-74-5986</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs.   | If Under 1 Year<br>Months Days                              | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>(Month, Day, Year)<br><b>09-17-63</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Md.</b> |
|  | Usual Residence of Decedent  |   |   |  |   |  |  |  |
| 10e. State<br><b>Md.</b>   |  | 10b. County<br><b>NA</b>  |   | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| 10e. Street and Number<br><b>3524 W. Franklin Street</b>   |  |   |   | 10f. Zip Code<br><b>21229</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th Grade</b><br>College (1-4or 5+) <b>NA</b>  |  |   |   | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Security Guard</b>   |   |  | 16b. Kind of Business/Industry<br><b>Facilities</b>  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Harry Forrester</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Peggy Powell</b>   |   |  |  |  |
| 19e. Informant's Name/Relationship (Type, Print)<br><b>Joan Graves</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21239 1923 Burnwood Road Baltimore, Maryland</b>  |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cem. 08-08-97 Owings Mills,</b>   |  |   | 20c. Location - City or Town, State <b>Md.</b>   |  |  |
| 21. Signature of Funeral Service Licensee<br>  |  |   |   | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>  |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>e. <b>SEIZURE DISORDER</b><br>Due to (or as a consequence of):<br><br>b.<br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |   |  |   |  |  | Approximate Interval Between Onset and Death           |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>CHRONIC ALCOHOL ABUSE</b>   |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |  |
|  |  |   |   |  |   | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |
|  |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>                             |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No               |  |
|  |  |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |   | 28d. Describe how injury occurred  |  |  |
|  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |  |  |
| 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |   |  |   |  |  |  |
| 29b. Signature and title of certifier<br>   |  |   |   | 29c. License number<br><b>O.C.M.E.</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 04, 1997</b>  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>J. Allen Locke, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  |   |   |  |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |   |   | 32. Registrar's Signature<br>   |   |  |  |  |

Baltimore, Maryland 21215-0020  
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





97-3742-510

AM

WILBERT

PARKER

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23941

ITEM: 10a,b,c,d per FH G-750 8-7-97 eoh

Physician  
/Medical  
Examiner

Wilbert Parker

2. Date of Death  
Month Day Year  
JULY 07, 1997  
3. Time of Death  
8:45 PFuneral  
Director

4e. Facility Name (If not institution, give street and number)

1808 E. MADISON ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

unknown

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

unknown

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

unknown

9. Birthplace (State or Foreign Country)

unknown

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

BALTIMORE CITY

10c. City, Town or Location

BALTIMORE

10d. Inside City Limits

unknown

10e. Street and Number

1808 E. Madison Street

10f. Zip Code

21205

10g. Citizen of What Country?

unknown

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces? 1 ☐ Yes 2 ☐ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

unknown

College (14 or 5+)

unknown

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

unknown

16b. Kind of Business/Industry

unknown

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

unknown

19a. Informant's Name/Relationship (Type, Print)

unknown

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

unknown

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☒ Other (Specify) in state

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. *Acute subarachnoid hemorrhage*

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number

OCME

29d. Date signed (Month, Day, Year)

JULY 08, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

THEODORE McKim

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Signature of Registrar

State Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23942

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Hallie C. Rupp

2. Date of Death

Month Day Year  
Aug. 4, 1997

3. Time of Death

12:50 AM

4a. Facility Name (If not institution, give street and number)

North Hampton Nursing Home

4b. City, Town, or Location of Death

Frederick

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

212-03-3055

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

86

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
Aug. 1, 1911

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Frederick

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

200 East 16th Street

10f. Zip Code

21701

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Salesperson

16b. Kind of Business/Industry

Retail

17. Father's Name (First, Middle, Last)

Alvie C. Keyser

18. Mother's Name (First, Middle, Maiden Surname)

Belle Z. Hamrick

19a. Informant's Name/Relationship (Type, Print)

Janis V. Marshall/Friend

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 East Main Street Thurmont, MD 21788

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Sacred Ht. of Jesus Cem. 8/7/97

Date

20c. Location - City or Town, State

Dundalk, Maryland

21. Signature of Funeral Service Licensee

▶ Johnny E. Eade

22. Name and Address of Facility

Duda-Ruck Funeral Home of Dundalk, Inc.  
7922 Wise Ave. Dundalk, Maryland 2122223a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

GANGRENE @ FOOT

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

~ 6 hrs

b.

DIABETES MELLITUS

Due to (or as a consequence of):

~ 10 yrs

c.

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or Injury  
that initiated events  
resulting in death) Last

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

COPD, DEMENTIA

VENOUS STASIS DERMATITIS

SPINAL STENOSIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide

{

28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

▶ [Signature]

29c. License number

D32171

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Richard Gough, MD 19 West Frederick St. Walkersville, Maryland 21793

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
ExaminerTo the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

ITEM: 23d, AMENDS PER DR. G-750 8-7-97 eoh **Certificate of Death**

Reg. No.

97 23943

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Calvin Coolidge Skidmore

2. Date of Death

Month Day Year  
June 11, 1997

3. Time of Death

2:00 A.M.

4a. Facility Name (If not institution, give street and number)

Prince George's Medical Center

4b. City, Town, or Location of Death

Cheverly

4c. County of Death

Prince George's

Funeral  
Director

5. Social Security Number

577-52-1126

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

72

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
Nov. 3, 1924

9. Birthplace (State or Foreign)

Washington DC

Usual Residence of Decedent

10a. State

Maryland

10b. County

Prince George's

10c. City, Town or Location

Hyattsville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

3334 Lancer Drive

10f. Zip Code

20783

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Dispatcher

16b. Kind of Business/Industry

Vending

17. Father's Name (First, Middle, Last)

Harry Skidmore

18. Mother's Name (First, Middle, Maiden Surname)

Lola May Parker

19a. Informant's Name/Relationship (Type, Print)

Craig Skidmore (Son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4830 Kingfisher Court Waldorf, MD 20603

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Peters Church Cem.

June 13, 1997

20c. Location - City or Town, State

Waldorf, Maryland

21. Signature of Funeral Service Licensee

St. E. Sitt

22. Name and Address of Facility Lee Funeral Home, Inc.

6633 Old Alexandria Ferry Rd Clinton, MD 20735

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. ACUTE MYOCARDIAL INFARCTION

1 HR

Due to (or as a consequence of):

b. PULMONARY EMBOLI

2 DAYS

Due to (or as a consequence of):

c. DEEP VEN THROMBOSIS @ LEG

3 DAYS

Due to (or as a consequence of):

d. CELLULITIS @ LEG / SPIDER BITE

10 DAYS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HYPERTENSION

OLD CEREBROVASCULAR EVENT

ANKYLOSING SPONDYLITIS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural5 ☐ Pending Investigation2 ☐ Accident6 ☐ Could not be determined3 ☐ Suicide4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Linda D Green MD

29c. License number

D21428

29d. Date signed (Month, Day, Year)

JUNE 11, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LINDA D GREEN PRINCE GEORGE'S HOSP CTR CHEVERLY, MD 20785

31. Date filed (Month, Day, Year)

JUN 17 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23944

## Certificate of Death

Reg. No.

|   |  |  |  |  |   |  |   |  |
|---|--|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>John George Scales</b>  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>AUG. 05, 1997</b>  |  | 3. Time of Death<br><b>0958 AM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>GOOD SAMARITAN HOSPITAL E.R.</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>212-36-2371</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>58</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>September 26, 1938</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Parkville</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 10e. Street and Number<br><b>7827 Birmingham Avenue</b>   |  | 10f. Zip Code<br><b>21234</b>   |  |
|   | 10g. Citizen of What Country?<br><b>United States</b>  |  |  |  | 11. Marital Status<br><input type="checkbox"/> Navar Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1955-1958</b>  |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: <b>White</b>  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>   |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Police Officer</b>   |  |  |  | 16b. Kind of Business/Industry<br><b>Baltimore City Police Department</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>John Joseph Scales</b>  |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Irene Aluerta Nightengale</b>  |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mrs. F. Arlene Scales / Wife</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>7827 Birmingham Avenue Baltimore, MD 21234</b>  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Gardens Of Faith</b>   |  | 20c. Location - City or Town, State<br><b>8/9/97 Baltimore, Maryland</b>  |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br><b>Leonard J. Ruck, Inc. Funeral Home</b>   |  |  |  | 22. Name and Address of Facility<br><b>5305 Harford Road Baltimore, MD 21214</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Multiple Injuries</b> |  |
|   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide            |  |
|   | 28a. Date of Injury (Month, Day Year)<br><b>8-5-97</b>   |  |  |  | 28b. Time of Injury<br><b>0900 M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred<br><b>Driver - auto - auto collision</b>   |  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br><b>Rehoboth</b>   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br><b>Perkins parkway and Taylor Ave</b>   |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>O.C.M.E</b>   |  |
| To Be Completed by Physician/Medical Examiner | 29d. Data signed (Month, Day, Year)<br><b>AUG. 06, 1997</b>  |  |  |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R Fowler 111 Penn Street, Baltimore, Maryland 21201</b>  |  | 31. Data filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  |
|   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |  |  | 33. Registrar's Name<br><b>Julia Davidson-Randall</b>   |  | 34. Registrar's Title<br><b>Registrar</b>   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23945

## Certificate of Death

Reg. No.

|   |  |  |   |  |   |  |  |  |
|---|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Sophie Ida Samaras</b>  |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>5</b> Year <b>1997</b>   |  | 3. Time of Death<br><b>1:14 AM</b>   |  |
|   | 4a. Facility Name (If not Institution, give street and number)<br><b>Good Samaritan Hospital</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>001-18-7818</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>May 23, 1923</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>New Hampshire</b>   |  | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Lutherville</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br><b>135 Warwick Road</b>   |  | 10f. Zip Code<br><b>21093</b>   |  | 10g. Citizen of What Country?<br><b>United States</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
| To Be Completed by Funeral Director           | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Telephone Operator</b>            |  | 16b. Kind of Business/Industry<br><b>Telecommunications</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>George Barry</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mary Millios</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Theodore Samaras</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>135 Warwick Road Lutherville, Maryland 21093</b> |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Blossom Hill</b>   |  | 20c. Location - City or Town, State<br><b>Concord, New Hampshire</b>  |  | 20d. Date<br><b>8/9/97</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>1050 York Road<br/>Ruck Towson Funeral Home, Inc. Towson, MD 21204</b>                                     |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><br>a. <b>Sepsis</b><br>Due to (or as a consequence of):<br><br>b. <b>Chronic Renal Failure</b><br>Due to (or as a consequence of):<br><br>c.<br>Due to (or as a consequence of):<br><br>d.<br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death   |  |
| To Be Completed by Physician/Medical Examiner | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  | 24e. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28d. Describe how Injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>   |  | 29c. License number<br><b>D0051293</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 6, 1997</b>   |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Michael Schmidt Good Samaritan Hospital</b>   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  | 32. Registrar's Signature<br>   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural," or items 23a or 24a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and completed, it must be filed in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23946

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Genevieve Eva Tutin

2. Date of Death

Month Day Year  
August 2, 1997

3. Time of Death

7:30 AM

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

8418 Sandy Plains Road

4b. City, Town, or Location of Death

Dundalk

4c. County of Death

Baltimore

5. Social Security Number

220-01-5761

6. Sex

1 ☐ M 2 ☒ F

7. Age (in yrs. last birthday)

73

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
May 27, 1924

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Dundalk

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8418 Sandy Plains Road

10f. Zip Code

21222

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

5 Years

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Karol Sobotka

18. Mother's Name (First, Middle, Maiden Surname)

Mary Anna Kocou

19a. Informant's Name/Relationship (Type, Print)

Mr. Edward Tutin/Husband

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

8418 Sandy Plains Road Dundalk, Maryland 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Sacred Heart of Jesus Cem. 8/5/97 Dundalk, Maryland

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Patrick M. Heming

22. Name and Address of Facility

7922 Wise Ave. Dundalk, MD 21222

Duda-Ruck Funeral Home, Of Dundalk, Inc.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a.

Pneumonia

Due to (or as a consequence of):

12 Hrs.

b.

Chronic Obstructive Lung Disease &gt; 20 yrs.

Due to (or as a consequence of):

c.

Atrial fibrillation.

Due to (or as a consequence of):

&gt; 2 yrs.

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery Disease

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOAOther: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Mohammed Khan, M.D.

29c. License number

D25391

29d. Date signed (Month, Day, Year)

8/4/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mohammed Khan, M.D. 5601 Loch Raven Blvd., Baltimore, Maryland

31. Date filed (Month, Day, Year)

AUG 17 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Registrar Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23947

Items: 10e-f, 18 per FH G-750 8/8/97 dh

## Certificate of Death

Reg. No.

|   |   |   |   |  |  |  |  |  |
|---|---|---|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>ALMA T. THOMAS</b>   |   |   |  | 2. Date of Death<br>Month <b>08</b> Day <b>03</b> Year <b>97</b>   |  | 3. Time of Death<br><b>3:45 PM</b>                                       |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-40-5684</b>   |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>92</b> Yrs. | If Under 1 Year<br>Months  | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth<br>Month, Day, Year<br><b>Aug 19, 1904 Maryland</b>     |  |
|   | Usual Residence of Decedent   |   |   |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>N/A</b>   | 10c. City, Town or Location<br><b>Baltimore</b>   |  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |
|   | 10e. Street and Number<br><b>2323 Montebello Terrace</b><br><b>428 E. 23rd St.</b>  |   |   | 10f. Zip Code<br><b>21218</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify <b>Colored</b> |  |
|   | 15. Decedent's Education<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>4+</b>  |   | 16a. Decedent's Usual Occupation<br>(Give kind of work done during most of working life. DO NOT use retired)<br><b>Teacher</b>                    |  | 16b. Kind of Business/Industry<br><b>Education</b>   |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 17. Father's Name (First, Middle, Last)<br><b>Lee Roy Taylor</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Phyllis Gwatney</b>  |  |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mr. Frederick Thomas (son)</b>   |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>6610 Southfield Rd. Fort Wash Md 20744</b>   |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |   | 20b. Place of Disposition (Name of cemetery, crematory, or other place)<br><b>Mt. Zion</b>  |  | 20c. Location - City or Town, State<br><b>8/11/97 Lansdowne, Md.</b>   |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br><b>Joseph L. Russ</b>  |   | 22. Name and Address of Facility<br><b>Joseph L. Russ Funeral Home</b><br><b>2222 W. North Ave. Balto. Md 21216</b>                               |  |  |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |   |   |  |  |  |  | Approximate interval between Onset and Death   |
| Immediate Cause (Final disease or condition resulting in death)<br>a. <b>Carcinoma of breast</b><br>Due to (or as a consequence of):  |   |   |   |  |  |  |  |  |
| Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br>b. Due to (or as a consequence of):   |   |   |   |  |  |  |  |  |
| c. Due to (or as a consequence of):   |   |   |   |  |  |  |  |  |
| d. Due to (or as a consequence of):   |   |   |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |   |   |  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|   |   |   |   |  |  |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|   |   |   |   |  |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  | 28d. Describe how Injury occurred  |
|   |   | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D 25391</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>8-4-97</b>   |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type/Print)<br><b>M. Khan 5601- Loch Raven Blvd. Baltimore MD 21229</b>   |   |   |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |   | 32. Registrar's Signature<br><b>[Signature]</b>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23948

DORIS TEIXEIRA

## Certificate of Death

Reg. No.

|   |  |   |   |  |   |  |  |  |
|---|--|---|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Doris H. Teixeira</b>   |   |   |  | 2. Date of Death<br>Month <b>AUGUST</b> Day <b>03</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>1:25 PM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>ST. AGNES HOSPITAL</b>  |   |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>214-12-0494</b>  |   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>77</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>March 3, 1920</b>  |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Maryland</b>   |  | 10b. County<br><b>Baltimore</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>5508 Lexington Road</b>  |  | 10f. Zip Code<br><b>21207</b>   |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Andrew Harding</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lula M. Mercer</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Manuel Teixeira (Husband)</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>5508 Lexington Road Baltimore, Maryland 21207</b>  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Owings Mills, Maryland</b>  |  | 20d. Date<br><b>August 7, 1997</b>   |  |
|   | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br><b>Witzke Funeral Home of Catonsville, Inc.<br/>1630 Edmondson Avenue Catonsville, Maryland 21222</b>   |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of): |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   | 23c. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   | 24a. Was an autopsy performed?<br><b>inspection</b><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
|   | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day Year)  |  |
|   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  | 28d. Describe how injury occurred   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |
|   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 04, 1997</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>David R. Fowler 111 Penn Street, Baltimore, Maryland 21201</b> |  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b> |   | 32. Registrar's Signature<br> |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23949

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

MARY TANNER

2. Date of Death

Month Day Year  
JULY 30 1997

3. Time of Death

7:39 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

NORTHWEST HOSPITAL CENTER

4b. City, Town, or Location of Death

RANDALSTOWN

4c. County of Death

BALTIMORE

5. Social Security Number

220-36-6446

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

57

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
NOV. 21, 1939

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

1915 BELMONT TERRACE

10f. Zip Code

21207

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: WHITE

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

11th

College (1-4 or 5+)

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

WAITRESS

16b. Kind of Business/Industry

RESTAURANT

17. Father's Name (First, Middle, Last)

THOMAS SEALS

18. Mother's Name (First, Middle, Maiden Surname)

NELLIE E. TANNER

19a. Informant's Name/Relationship (Type, Print)

NELLIE E. GIBSON (MOTHER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1915 BELMONT TERRACE CATONSVILLE MARYLAND 21207

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

CARROLL CREMATION SERVICE 08-03-97 HAMPSTEAD MARYLAND

Date

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Robert Eugene Bush

22. Name and Address of Facility

WITZKE FUNERAL HOME OF CATONSVILLE, INC.

1630 EDMONDSON AVENUE CATONSVILLE MARYLAND 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☒ Outpatient3 ☐ DOAOther: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicidal4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Michael Rothkin

29c. License number

043491

29d. Date signed (Month, Day, Year)

JULY 30, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MICHAEL ROTHKIN 5401 OLD COURT ROAD RANDALSTOWN, MARYLAND 21133

31. Date filed (Month, Day, Year)

AUG 07 1997

32. Registrar's Signature

Julia Davidson-Rodriguez

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23950

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

CARL URIE

2. Date of Death

August 6 1997

3. Time of Death

2:40 PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

MERCY HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

214-64-4015

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

41 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

November 3, 1955

9. Birthplace (State or Foreign Country)

Baltimore

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5412 Gerland Avenue

10f. Zip Code

21206

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
if Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Supermarket Manager

16b. Kind of Business/Industry

Retail Grocery

17. Father's Name (First, Middle, Last)

Robert L. Urie, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Eckles

19a. Informant's Name/Relationship (Type, Print)

Mrs. Doreen M. Urie / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

5412 Gerland Avenue Baltimore, Md. 21206

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Gardens of Faith Cemetery

Date

8/9/97

20c. Location - City or Town, State

Baltimore, Maryland

21. Signature of Funeral Service Licensee Mark T. Zavoyna

Mark T. Zavoyna

22. Name and Address of Facility

Leonard J. Ruck, Inc.

5305 Harford Road Baltimore, Md. 21214

23a. Part I. Enter the disease and complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)a. Pneumonia  
Due to (or as a consequence of):Approximate  
Interval Between  
Onset and Death

2 wks

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. Small Cell Lung Cancer  
Due to (or as a consequence of):

6 months

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending  
Investigation 6 ☐ Could not be  
determined

28a. Date of Injury

(Month, Day Year)

28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Jose Costa, MD

29c. License number

DA2634

29d. Date signed (Month, Day, Year)

August 6 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH COSTA

301 ST. PAUL PLACE BALTIMORE, MD 21202

31. Date filed (Month, Day, Year)

AUG 07 1997

Julia P. [Signature]

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23951

Reg. No.

|  |  |  |   |   |  |   |   |  |
|--|--|--|---|---|--|---|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Rose Marie WILSON</b>   |  |   |   | 2. Date of Death<br>Month <b>July</b> Day <b>31</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>12:45P.M.</b>  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br><b>Franklin Square Hospital Center</b>   |  |   |   | 4b. City, Town, or Location of Death<br><b>Rosedale</b>  |   | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-32-6559</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>61</b> Yrs.   |   | 8. Date of Birth (Month, Day, Year)<br><b>Dec. 15, 1935</b>   |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |  |   |   |  |   |   |  |
| To Be Completed by Funeral Director  | 10a. State<br><b>Maryland</b>  |  | 10b. County<br><b>Baltimore</b>   |   | 10c. City, Town or Location<br><b>Dundalk</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 10e. Street and Number<br><b>1912 Haselmere Road</b>   |  |   |   | 10f. Zip Code<br><b>21222</b>  |   | 10g. Citizen of What Country?<br><b>United States</b>   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |   | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>   |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12 Years</b><br>College (1-4 or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Manager</b>   |   | 16b. Kind of Business/Industry<br><b>Blind Industry Managing</b>   |   |   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Robert Lacey McMullen</b>  |  |   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Fannie Marie Clark</b>   |   |   |  |
| Physician<br>/Medical<br>Examiner  | 19a. Informant's Name/Relationship (Type, Print)<br><b>James H. Wilson/Husband</b>   |  |   |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1912 Haselmere Road Dundalk, Maryland 21222</b>  |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Cedar Hill Cemetery</b>  |   | Date<br><b>8/4/1997</b>  |   | 20c. Location - City or Town, State<br><b>Glen Burnie, Maryland</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><i>[Signature]</i>  |  |   |   | 22. Name and Address of Facility<br><b>Duda-Ruck Funeral Home of Dundalk, Inc.<br/>7922 Wise Ave. Dundalk, Maryland 21222</b>  |   |   |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. Atherosclerotic cardiovascular disease</b>  |  |   |   | Approximate Interval Between Onset and Death<br><b>5 years</b>   |   |   |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |   |  |   |   |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|  |  |  |   |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
|  |  |  |   |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |   |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide                        |  | 28a. Date of Injury (Month, Day Year)   |   | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   |   |  | 28d. Describe how injury occurred                           |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |   |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |   |   |  |   |   |  |
| 29b. Signature and title of certifier<br><b>Dr. Julie Ann Casani MD</b>  |  |  |   | 29c. License number<br><b>D28214</b>            |  | 29d. Date signed (Month, Day, Year)<br><b>July 31, 1997</b> |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Dr. Julie Ann Casani 9000 Franklin Square Dr. Baltimore, Maryland 21237</b>   |  |  |   |   |  |   |   |  |
| 31. Data filed (Month, Day, Year)<br><b>AUG 07 1997</b>  |  |  |   | 32. Registrar's Signature<br><i>[Signature]</i> |  |   |   |  |

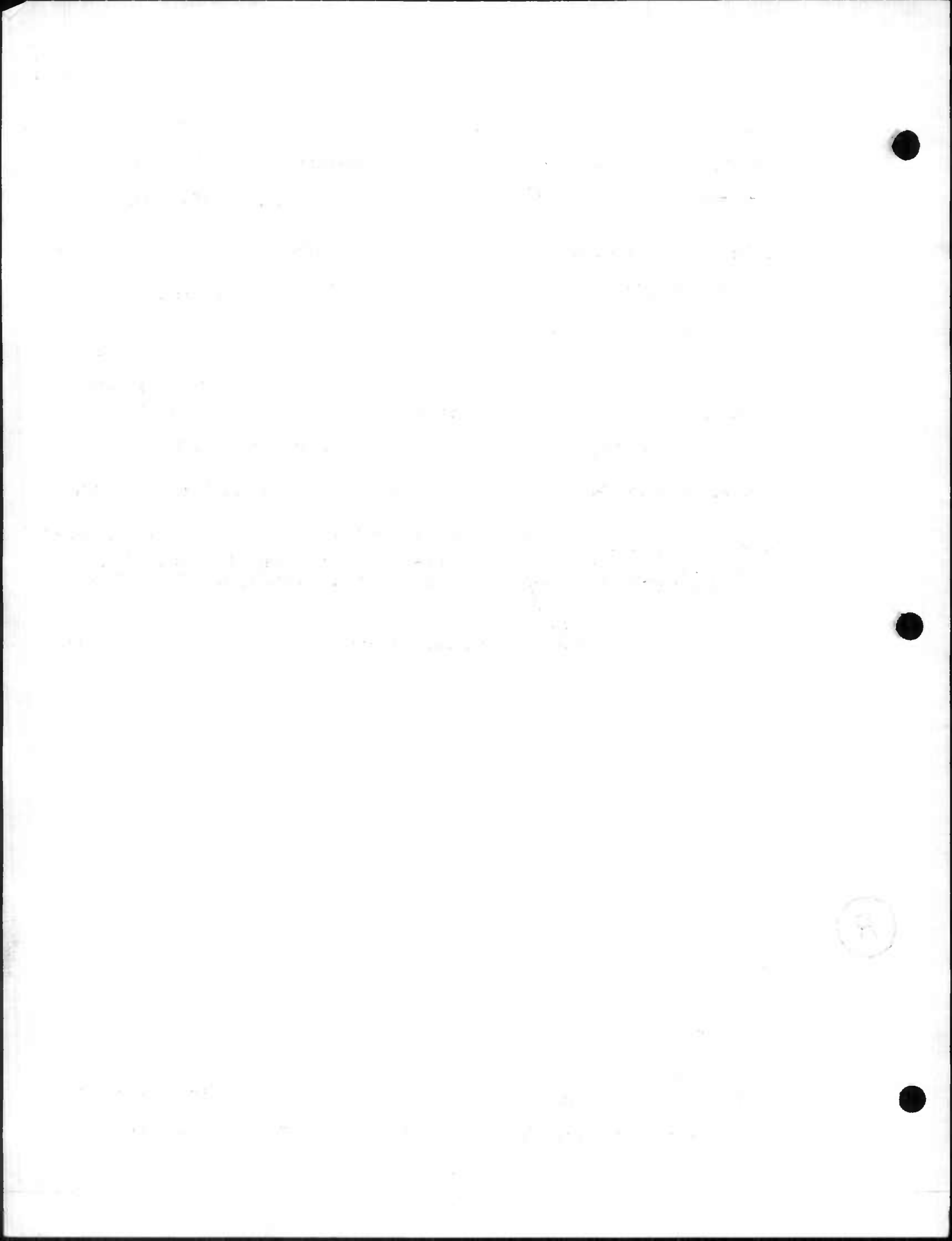
Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23952

## Certificate of Death

Reg. No.

|  |   |  |   |  |  |  |  |  |  |  |
|--|---|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>Anna Elizabeth Young</b>   |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>3</b> Year <b>1997</b>  |  |  |  | 3. Time of Death<br><b>2:30 PM</b>                     |  |
|  | 4e. Facility Name (If not institution, give street end number)<br><b>Genesis Eldercare- Randallstown Center</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>Randallstown</b>  |  |  |  | 4c. County of Death<br><b>Baltimore</b>                |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>213-74-9758</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>103</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>October 18, 1893</b>   |  | 9. Birthplace (State or Foreign Country)<br><b>MD.</b> |  |
|  | Usual Residence of Decedent   |  |   |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Randallstown</b>     |  |
| To Be Completed by Funeral Director                                  | 10e. Street end Number<br><b>9101 Liberty Rd.</b>   |  |   |  | 10f. Zip Code<br><b>21133</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:     |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>5</b> College (1-4 or 5+)   |  | 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Homemaker</b>   |  | 16b. Kind of Business/Industry<br><b>Own Home</b>  |  |  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Henry Horstmann</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elizabeth Pohl</b>   |  |  |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gordon J. Young (son)</b>  |  |   |  | 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)<br><b>223 Warren Rd. Cockeysville, MD. 21030</b>   |  |  |  |  |  |
|  | 20e. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Parkwood Cemetery</b>  |  | Date<br><b>8/6/97</b>  |  | 20c. Location - City or Town, State<br><b>Parkville, MD.</b>   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><b>Dennis C. Carroll</b>   |  |   |  | 22. Name and Address of Facility<br><b>Ruck Towson Funeral Home, Inc.<br/>1050 York Rd. Towson, MD. 21204</b>  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>ASHD</b>  |  |   |  | Approximate Interval Between Onset and Death   |  |  |  |  |  |
|  | Immediate Cause (Final disease or condition resulting in death)<br><b>ASHD</b>  |  |   |  | Due to (or as a consequence of):   |  |  |  |  |  |
|  | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>peripheral Vascular Disease</b>  |  |   |  | Due to (or as a consequence of):   |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>peripheral Vascular Disease</b>  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |  |  |  |
|  |   |  |   |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |  |  |
|  | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28e. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how injury occurred                      |  |
|  |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street end Number or Rural Route Number, City or Town, State)   |  |  |  |
|  | 29e. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |   |  | 29c. License number<br><b>D17118</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8/4/97</b>   |  |  |  |
|  | 29b. Signature and title of certifier<br><b>Medical Attending</b>   |  |   |  |  |  |  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Paul Schwaert M.D. 4000 Old Court Rd #203</b>  |  |   |  |  |  |  |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |  | 32. Registrar's Signature<br><b>J. Davidson</b>   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or item 23a or 23a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

10. Hospital or Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

11. Funeral Director: After this certificate has been signed by the attending physician and completed by the funeral director, page 2 should be detached for use as the burial-transit form.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23953

## Certificate of Death

Reg. No.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Winnie Young</b>   |   | 2. Date of Death<br>Month <b>July</b> Day <b>20</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>1740</b>  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>PENINSULA REGIONAL MEDICAL CENTER</b>  |   | 4b. City, Town, or Location of Death<br><b>SALISBURY</b>   |   | 4c. County of Death<br><b>WICOMICO</b>   |
| Funeral<br>Director   | 5. Social Security Number<br><b>219-07-7209</b>   | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.   | 8. Date of Birth (Month, Day, Year)<br><b>June 24, 1923</b> | 9. Birthplace (State or Foreign Country)<br><b>unknown</b>                                     |
|   | Usual Residence of Decedent   |   |  |   |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Maryland</b>   | 10b. County<br><b>Wicomico</b>  | 10c. City, Town or Location<br><b>Salisbury</b>  |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
|   | 10e. Street and Number<br><b>521 Alabama Avenue #1</b>  |   | 10f. Zip Code<br><b>21801</b>  |   | 10g. Citizen of What Country?<br><b>U.S.A.</b>   |
|   | 11. Marital Status<br><b>unknown</b><br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>unknown</b> College (1-4 or 5+) <b>unknown</b>  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Librarian</b>   |   | 16b. Kind of Business/Industry<br><b>library</b>   |
|   | 17. Father's Name (First, Middle, Last)<br><b>unknown</b>   |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>  |   |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Cherry Baker/daughter</b>  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>521 Alabama Avenue, Salisbury, Maryland 21801</b>  |   |  |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify)   |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</b>                                      |   | 20c. Location - City or Town, State  |
|   | 21. Signature of Funeral Service Licensee<br><b>Ronald S. Wade, Director</b>  |   | 22. Name and Address of Facility<br><b>State Anatomy Board, 655 W. Baltimore Street Baltimore, Maryland 21201</b>  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |  |   |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Acute left intracerebral haematoma</b><br>Due to (or as a consequence of):<br>b. <b>cerebral atherosclerosis</b><br>Due to (or as a consequence of):<br>c. _____<br>Due to (or as a consequence of):<br>d. _____ |   |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Hypertension, Angina pectoris</b>  |   |   |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |   |  |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |   |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |   |   |  |   |  |
| 28a. Date of Injury (Month, Day Year)<br><b>July 20, 1997</b>   |   |   |  |   |  |
| 28b. Time of Injury<br><b>M</b>   |   |   |  |   |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |  |   |  |
| 28d. Describe how injury occurred   |   |   |  |   |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |   |  |   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |   |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |   |  |   |  |
| 29b. Signature and title of certifier<br><b>[Signature]</b>   |   |   |  |   |  |
| 29c. License number<br><b>018614</b>  |   |   |  |   |  |
| 29d. Date signed (Month, Day, Year)<br><b>07.21.97.</b>   |   |   |  |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>DEEPAK SAGGAR MD, 547-G RIVERSIDE DR. SALISBURY MD-21801</b>   |   |   |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 07 1997</b>   |   |   |  |   |  |
| 32. Registrar's Signature<br><b>[Signature]</b>   |   |   |  |   |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23e or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 97 23954

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John H. Allen

2. Date of Death  
Month Day Year  
August 6, 1997

3. Time of Death  
2:15pm

4a. Facility Name (If not institution, give street and number)

1711 Jackson Street

4b. City, Town, or Location of Death

Baltimore City

4c. County of Death

N/A

5. Social Security Number

220-36-3077

6. Sex

Male ☒ Female ☐

7. Age (In yrs. last birthday)

56 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

October 27, 1940

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore City

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1711 Jackson Street

10f. Zip Code

21230

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 58-61

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

To Be Completed by Funeral Director

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Grade

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Locomotive Engineer

16b. Kind of Business/Industry

Transportation

17. Father's Name (First, Middle, Last)

Henry William Allen

18. Mother's Name (First, Middle, Maiden Surname)

Theresa K. Kuciej

19a. Informant's Name/Relationship (Type, Print)

Rosemarie B. Allen / Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1711 Jackson Street, Baltimore Maryland 21230

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Glen Haven Memorial Park

Date

August 9, 1997

20c. Location - City or Town, State

Baltimore Maryland

21. Signature of Funeral Service Licensee

*[Signature]*

22. Name and Address of Facility

Charles L. Stevens Funeral Home, Inc.  
1501 East Fort Avenue, Baltimore Maryland 21230

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA LUNG

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

1 MONTH

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*[Signature]*

29c. License number

019640

29d. Date signed (Month, Day, Year)

8/7/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MARC S. ROSNER MD 1147 S. HANOVER ST BALTO MD 21230

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

*[Signature]*

State Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Registrar: The law requires that the death certificate be executed within 72 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23955

|   |   |  |  |  |   |  |   |  |
|---|---|--|--|--|---|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Mary Pearl Amos</b>  |  |  |  | 2. Date of Death<br>Month <b>Aug</b> 3, 1997 Year   |  | 3. Time of Death<br><b>8:58 PM</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Atlantic General Hospital</b>  |  |  |  | 4b. City, Town, or Location of Death<br><b>BERLIN</b>   |  | 4c. County of Death<br><b>WORCHESTER</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>217 26 5485</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>84</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>Feb. 18, 1913</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  | 10a. State<br><b>MARYLAND</b>  |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>WHITE HALL</b>  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>20614 West Liberty Rd.</b>   |  | 10f. Zip Code<br><b>21161</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:     |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>   |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>n/a</b>                |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Factory Worker</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Tool &amp; Die</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>Bosley Baublitz</b>   |  |
| To Be Completed by Physician/Medical Examiner | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Agnes Marie Tillman</b>   |  |  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Mary L. Heath/Daughter</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>20328 Kirkwood Shop Rd., White Hall, MD 21161</b> |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. James Episcopal Cemetery</b>   |  | 20c. Location - City or Town, State<br><b>Monkton, MD</b>   |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Home Director<br><b>Bryan W. Clary</b>   |  |  |  | 22. Name and Address of Facility<br><b>Lemmon Funeral Home of Dulany Valley, Inc.<br/>10 W. Padonia Rd., Timonium, MD 21093</b>   |  |   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>7 TO CARDIAC INFARCTION</b><br>Due to (or as a consequence of):<br><b>CORONARY ARTERY DISEASE</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |  |  |  | Approximate Interval Between Onset and Death<br><b>1 HE</b><br><b>10 YEARS</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>UNKNOWN CARDIOMYOPATHY</b>   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined   |  |  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  |
| To Be Completed by Physician/Medical Examiner | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 28d. Describe how injury occurred   |  |   |  |
|   | 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.     |  |  |  | 29c. License number<br><b>D33011</b>  |  |   |  |
|   | 29b. Signature and title of certifier<br><b>Bryan W. Clary MD</b>   |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>8/6/97</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Robert Wiedefeld, M.D., 3346 Papermill Rd., Phoenix, MD 21131</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |  |   |  |
|   | 32. Registrar's Signature<br><b>Jika Davidson-Randall</b>   |  |  |  | 33. State Registrar<br><b>State Registrar</b>   |  |   |  |



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23956

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Sophie C Benesch

2. Date of Death

Month Day Year  
AUGUST 5, 1997

3. Time of Death

4:00 A.M.

4a. Facility Name (If not institution, give street and number)

CHESAPEAKE HOSPICE

4b. City, Town, or Location of Death

GLEN BURNIE

4c. County of Death

ANNE ARUNDEL

Funeral  
Director

5. Social Security Number

217-16-3398

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

76 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Month Day Year  
1/24/1921

9. Birthplace (State or Foreign Country)

MARYLAND

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

GLEN BURNIE

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1517 HODGES AVENUE

10f. Zip Code

21060

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☒ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1944-1948

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12

College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

REGISTERED NURSE

16b. Kind of Business/Industry

HOSPITAL

17. Father's Name (First, Middle, Last)

KONSTANT BENESCH

18. Mother's Name (First, Middle, Maiden Surname)

CONSTANCE SADOWSKI

19e. Informant's Name/Relationship (Type, Print)

HELEN BENESCH - SISTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1517 HODGES AVENUE, GLEN BURNIE, MD 21060

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GLEN HAVEN MEM. PK.

Date

8/8/97

20c. Location - City or Town, State

GLEN BURNIE, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

RAYMOND C. FINK FUNERAL HOME  
426 CRAIN HWY., SW, GLEN BURNIE, MD 21061

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Metastatic Carcinoma of the Uterus 1 year  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Physician  
/Medical  
Examiner

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

031551

29d. Date signed (Month, Day, Year)

August 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daniel A. Belue 1600 S-Crain Highway Suite 602, Glen Burnie, MD 21061

31. Date signed (Month, Day, Year)

AUG 8 1997

32. Registrar's Signature

State  
Registrar

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be attached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural," or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23957

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOVISAH NELSON BUMGARNER

2. Date of Death

Month August Day 5, Year 1997

3. Time of Death

3:45 P.M.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Brightwood

4b. City, Town, or Location of Death

Lutherville

4c. County of Death

Baltimore

5. Social Security Number

220-46-8288

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

99 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)

April 12, 1898

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Baltimore

10c. City, Town or Location

Lutherville

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

515 Brightfield Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

Collegiate (1-4 or 5+)

3 years

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Nurse

16b. Kind of Business/Industry

Medical

17. Father's Name (First, Middle, Last)

Josuha

Nelson

18. Mother's Name (First, Middle, Maiden Surname)

Amanda

Shelley

19a. Informant's Name/Relationship (Type, Print)

Barbara B. Robertson (daughter)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15355 Old York Road, Monkton, Maryland 21111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

St. James Episcopal Church Cem. 8-8-97

20c. Location - City or Town, State

Monkton, Maryland

21. Signature of Funeral Service Licensee

*George Fenn*

22. Name and Address of Facility

Mitchell-Wiedefeld Home

6500 York Road Baltimore, Maryland 21212

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. *Generalized Atherosclerosis*

Due to (or as a consequence of):

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

*Hypertension**Lupus**Dementia*

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

*Sheldon Goldgeier MD*

29c. License number

DO 2397

29d. Date signed (Month, Day, Year)

8-6-97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Sheldon Goldgeier MD 711 W 40<sup>th</sup> Street Baltimore MD 21241

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

*Julia Davidson-Randall*State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23958

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

NELLIE

BELFE

2. Date of Death

Month

Day

Year

AUG

06

1997

3. Time of Death

7:40 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

GENESIS/MERIDIAN ELDER CARE NURSING HOME

4b. City, Town, or Location of Death

DUNDALK

4c. County of Death

BALTIMORE

5. Social Security Number

216-18-7375

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

96

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

Sep. 1, 1900

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10e. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

DUNDALK

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

7232 GERMAN HILL RD

10f. Zip Code

21222

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give

Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No-

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian,

Black, White, etc.

Specify: White

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

8 yrs

16. Decedent's Usual Occupation

(Give kind of work done during most of working

life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Unk.

18. Mother's Name (First, Middle, Maiden Surname)

Unk.

19a. Informant's Name/Relationship (Type, Print)

Mark Wittstadt/Atty.

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

6905 Dunmanway Suite A/Dundalk, Md. 21222

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of

cemetery, crematory or other place)

Most Holy Redeemer

Date

8-7-97

20c. Location - City or Town, State

Balto., Md. 21222

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

BRADLEY-ASHTON FUNERAL HOME, INC.

2134 WILLOW SPRING ROAD, DUNDALK 21222

23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

UROSEPSIS

Approximate Interval Between Onset and Death

Days

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DIABETES MELLITUS

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

29b. Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Surjit A. Julka

29c. License number

D 26395

29d. Date signed (Month, Day, Year)

8/6/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. SURJIT JULKA

821 N. EUTAW ST. SUITE 407 BALTIMORE MD 21201

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23959

## Certificate of Death

Reg. No.

|  |  |   |  |   |  |                          |   |  |  |  |
|--|--|---|--|---|--|--------------------------|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>James Brookman Sr.</b>                                |   |  |   | 2. Date of Death<br>Month Day Year<br><b>Aug 7 1997</b>  |                          |   |  | 3. Time of Death<br><b>00 50</b>                       |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Anne Arundel Medical Center</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Annapolis</b> |                          |   |  | 4c. County of Death<br><b>Anne Arundel</b>             |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>216-18-5270</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>97</b> Yrs.         |                          | 8. Date of Birth (Month, Day, Year)<br><b>Jun 14 1900</b> |  | 9. Birthplace (State or Foreign Country)<br><b>Va.</b> |  |
|  | Usual Residence of Decedent  |   |  |   |  |                          |   |  |  |  |
| 10a. State<br><b>Md</b>  |  | 10b. County<br><b>Anne Arundel</b>  |  | 10c. City, Town or Location<br><b>Riva</b>  |  |                          |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |
| 10e. Street and Number<br><b>200 Ridge Road</b>  |  |   |  | 10f. Zip Code<br><b>21140</b>   |  |                          |   | 10g. Citizen of What Country?<br><b>USA</b>  |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |                          |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>0</b> Collage (1-4or 5+) <b>Collage</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Farmer/Lumberman</b>  |  |                          |   | 16b. Kind of Business/Industry<br><b>Farming</b>   |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>James Brookman</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Lucy Maubray</b>  |  |                          |   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James Brookman Jr./Son</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>247 W. Central Ave., Edgewater, MD 21037</b>  |  |                          |   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Lakemont Cemetery</b>  |  | Date<br><b>8/11/97</b>   |   | 20c. Location - City or Town, State<br><b>Davidsonville Md</b>                                 |  |  |
| 21. Signature of Funeral Service Licensee<br><i>Thomas A. Brooks</i>   |  |   |  | 22. Name and Address of Facility<br><b>Hardesty Funeral Home, P.A., 12 Ridgely Ave., Annapolis, Md 21401</b>  |  |                          |   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Cerebrovascular accident</b><br>Due to (or as a consequence of):<br><b>b. Dilated Cardiomyopathy</b><br>Due to (or as a consequence of):<br><b>c. Coronary artery disease</b><br>Due to (or as a consequence of):<br><b>d.</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>{</b> |  |   |  |   |  |                          |   |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |   |  |                          |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |   |  |                          |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |   |  |                          |   |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Parkinson's</b><br><b>COPD</b>  |  |   |  |   |  |                          |   |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |                          |   |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  |  |   |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |  |  |
|  |  |   |  | 28d. Describe how Injury occurred   |  |                          |   | 28e. Location (Street and Number or Rural Route Number, City or Town, State)                   |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  | 29b. Signature and title of certifier<br><i>Susan Krieger, MD</i>   |  |                          |   | 29c. License number<br><b>D44838</b>   |  |  |
|  |  |   |  | 29d. Date signed (Month, Day, Year)<br><b>8-7-97</b>  |  |                          |   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>SUSAN KRIEGER, MD 134 Owensville Rd West River, MD 20778</b>  |  |   |  |   |  |                          |   |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>  |  |   |  | 32. Registrar's Signature<br><i>J. Davidson-Randall</i>   |  |                          |   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23960

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |  |  |
|---|--|---|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>CATHERINE EILEEN BAGDON</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 5 1997</b>   |  | 3. Time of Death<br><b>9:30 A.M.</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>MANOR CARE ROLAND PARK N.H.</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| 5. Social Security Number<br><b>214-22-7064</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>6/5/17</b>   |  |
| 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>   |  |   |  |  |  |  |  |
| 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>COCKEYSVILLE</b>   |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 10e. Street and Number<br><b>8 WARREN LODGE COURT</b>   |  |   |  | 10f. Zip Code<br><b>21030</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b>  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th GRADE</b><br>College (1-4 or 5+) <b>ADMINISTER</b>   |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  |  | 16b. Kind of Business/Industry<br><b>STATE OF MARYLAND</b>   |  |
| 17. Father's Name (First, Middle, Last)<br><b>JOSEPH ELLIOTT</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MARY ANN TRESS</b>   |  |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>FRANK J. BAGDON, JR. SON</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1902 EDGEWOOD ROAD BALTIMORE, MD 21234</b>   |  |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>DULANEY VALLEY MEM. GAR.</b>   |  | 20c. Date<br><b>8/9/97</b>   |  | 20d. Location - City or Town, State<br><b>COCKEYSVILLE, MD</b>   |  |
| 21. Signature of Funeral Service Licensee<br><i>Christina A. Kopycz</i>   |  |   |  | 22. Name and Address of Facility<br><b>JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286</b>   |  |  |  |
| 23a. Per 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. <b>DECUBITI</b><br>Due to (or as a consequence of):<br><br>b. <b>SEPSIS, PNEUMONIA, TOXIC SYNDROME</b><br>Due to (or as a consequence of):<br>c. <b>Protein-calorie malnutrition</b><br>Due to (or as a consequence of):<br>d. <b>1 MONTH</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>atherosclerotic Cardiovascular Disease</b><br><b>Concussion, Depression</b>  |  |   |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> LOA Other: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  |
| 28d. Describe how injury occurred   |  |   |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  |   |  |  |  |  |  |
| 29b. Signature and title of certifier<br><i>Harold B. Chen, MD</i>  |  |   |  | 29c. License number<br><b>D21680</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>August 5, 1997</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>6717 Park Heights Avenue Baltimore, Maryland 21215</b>   |  |   |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |  |   |  | 32. Registrar's Signature<br><i>J. A. W. Randolph</i>  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

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Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23961

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |   |  |  |
|---|---|--|--|--|--|--|---|---|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>CLARA L. BASEY</b>   |  |  |  |  |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 5 1997</b>                                  |   | 3. Time of Death<br><b>9:18 pm</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>CHURCH HOME HOSPITAL</b>   |  |  |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>                               |   | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>216-68-4274</b>   |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>54</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>APR. 23, 1943</b>                                 |   | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  |
|   | Usual Residence of Decedent   |  |  |  |  |  |   |   |  |  |
| To Be Completed by Funeral Director           | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  |   |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |
|   | 10e. Street and Number<br><b>1212 MAPLE LEAF COURT</b>  |  |  |  | 10f. Zip Code<br><b>21202</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>  |   |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>NEGRO</b> |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>8TH</b> College (1-4or 5+) <b>N/A</b>   |  |  |  | 18e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>UNEMPLOYED</b>   |  |   | 16b. Kind of Business/Industry<br><b>N/A</b>                            |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>RUSSELL MILLER</b>  |  |  |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>MATTIE JONES</b>                    |   |  |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>JAMIE PARKS - son</b>  |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>417 BRADFORD ST. BALTO, MD. 21224</b>  |  |   |   |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>MT. ZION CEMETERY</b>   |  | Date<br><b>AUG. 12, 1997</b>   |  | 20c. Location - City or Town, State<br><b>BALTO, MD.</b>                                    |   |  |  |
|   | 21. Signature of Funeral Service Licensee<br><i>Calvin B. Scruggs, Jr.</i>  |  |  |  | 22. Name and Address of Facility<br><b>CALVIN B. SCRUGGS FUNERAL HOME<br/>1412 E. PRESTON STREET, BALTO, MD. 21213</b>   |  |   |   |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>e. <b>Respiratory Failure</b><br>Due to (or as a consequence of):<br>b. <b>Pneumonia</b><br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d.<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |  |  |  |  |   |   |  |  |
|   | Approximate Interval Between Onset and Death<br>acute<br>acute  |  |  |  |  |  |   |   |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>POSITIVE HIV STATUS</b><br><b>old CVA</b><br><b>Carcinoma of Colon</b>   |  |  |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |  |
|   |   |  |  |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |
|   |   |  |  |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospice: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |   |  |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide   |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   | 28d. Describe how injury occurred  |  |
|   |   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)                |   |  |  |
|   | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |  | 29b. Signature and title of certifier<br><i>R. Bokhari M.D.</i>  |  | 29c. License number<br><b>D-26594</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>AUG 5 1997</b>                                    |   |  |  |
|   | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>R. BOKHARI M.D. 100 N. BROADWAY BALTIMORE MD 21231</b>   |  |  |  |  |  |   |   |  |  |
|   | 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |  | 32. Registrar's Signature<br><i>Davidson-Randall</i>   |  |  |  |   |   |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



WRC  
97-4304-510  
ROBERT W.  
CONE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23962

Items: 23a part I, 27, 28a-f per ME0 G-750 8/13/97 dh

Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ROBERT W. CONE, SR.

2. Date of Death

Month Day Year  
AUG. 03, 1997

3. Time of Death

6:15 AM.

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

544 E. 22nd ST.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

257-96-8773

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

40 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
09/09/1956

9. Birthplace (State or Foreign Country)

WASHINGTON D.C.

Usual Residence of Decedent

10a. State

MD

10b. County

ANNE ARUNDEL

10c. City, Town or Location

LINTHICUM

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

301 DARLENE AVE.

10f. Zip Code

21090

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: WHITE

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

4 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SYSTEMS ENGINEER

16b. Kind of Business/Industry

COMPUTER

17. Father's Name (First, Middle, Last)

WILLIAM HENRY CONE

18. Mother's Name (First, Middle, Maiden Surname)

EDITH CLEVE TURNER

19a. Informant's Name/Relationship (Type, Print)

ELIZABETH CONE/ WIFE

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

301 DARLENE AVE. LINTHICUM, MD 21090

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

NEW CATHEDRAL CEMETERY

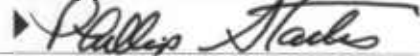
Date

8/8/97

20c. Location - City or Town, State

BALTIMORE, MD

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

STERLING ASHTON FUNERAL HOME, INC.  
736 EDMONDSON AVE. CATONSVILLE, MD 21228

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. NARCOTIC AND ALCOHOL INTOXICATION

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☒ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☒ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☒ Yes 2 ☐ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

AT  
SCENE

27. Manner of Death

1 ☐ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☒ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

found 8/3/97

28b. Time of Injury

found 1:30M

28c. Injury at Work?

1 ☐ Yes 2 ☒ No

28d. Describe how injury occurred

unknown

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

found at a friend's home

28f. Location (Street and Number or Rural Route Number, City or Town, State) 544 22nd. Street, Baltimore, Maryland

29a. Certifier (Check only one)

1 ☐ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☒ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

AUG 03, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

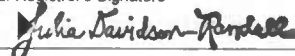
David R Fowler 111 Penn Street, Baltimore, Maryland 21201

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature



Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23963

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

DORETHA DURHAM

2. Date of Death

AUG 01 1997 12:15 AM

3. Time of Death

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

BON SECOUR HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

5. Social Security Number

228-36-0155

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

64

Yrs.

If Under 1 Year

Montha Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

MARCH 18, 1933

9. Birthplace (State or Foreign Country)

VIRGINIA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1530 BAKER STREET

10f. Zip Code

21217

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

3RD GRADE

College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

HOUSEWIFE

16b. Kind of Business/Industry

OWN HOME

17. Father's Name (First, Middle, Last)

WILLIAM WARREN

18. Mother's Name (First, Middle, Maiden Surname)

MARY EASTER

19a. Informant's Name/Relationship (Type, Print)

CLEADER WARREN (DAUGHTER)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

1530 BAKER ST., BALTIMORE, MARYLAND 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST CEMETERY

Date

8-6-97

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

SUBBROWN

22. Name and Address of Facility

JOSEPH H. BROWN JR. FUNERAL HOME, P.A.  
2140 N. FULTON AVE., BALTIMORE, MD 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic carcinoma of colon  
Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Renal Failure  
Diabetes Mellitus, insulin dependent  
Hypertension; arteriosclerotic Heart Disease

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

J. S. Seldin MD

29c. License number

D16263

29d. Date signed (Month, Day, Year)

Aug 01, 1997

30. Name and address of person who completed cause of death (from 23a) (Type, Print)

JUAN A. BELTRAN 1940 W. BALT ST, BALT, MD 21223

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Julia Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospitalizing Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

8. The first condition is

that the function  $f$  is continuous

on the interval  $[a, b]$ .

and that the function  $g$  is continuous

on

$[a, b]$  and that the function  $h$  is continuous

on the interval  $[a, b]$ .

and

that the function  $f$  is continuous

on the interval  $[a, b]$  and that the function  $g$  is continuous

on the interval  $[a, b]$ .

and

that

the function  $f$  is continuous

on the interval  $[a, b]$

and that the function  $g$  is continuous

on the interval  $[a, b]$ .

and that the function  $h$  is continuous

on the interval  $[a, b]$  and that the function  $f$  is continuous

on the interval  $[a, b]$  and that the function  $g$  is continuous

on the interval  $[a, b]$  and that the function  $h$  is continuous

on the interval  $[a, b]$  and that the function  $f$  is continuous

on the interval  $[a, b]$  and that the function  $g$  is continuous

on

the interval  $[a, b]$  and that the function  $f$  is continuous

on the interval  $[a, b]$  and that the function  $g$  is continuous

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23964

Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |  |  |  |  |
|--|--|--|---|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br>NORMA DUNLOP   |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br>AUGUST 5, 1997                                 |  | 3. Time of Death<br>13:00 p  |  |
|  | 4a. Facility Name (If not Institution, give street and number)<br>THE JOHNS HOPKINS HOSPITAL   |  |   |  |  |  | 4b. City, Town, or Location of Death<br>BALTIMORE CITY                               |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director  | 5. Social Security Number<br>186-18-3165   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>77 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JUL 14, 1920                                  |  | 9. Birthplace (State or Foreign Country)<br>Pennsylvania   |  |
|  | Usual Residence of Decedent  |  |   |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director                                  | 10a. State<br>FL   |  | 10b. County<br>Lee  |  | 10c. City, Town or Location<br>Cape Coral  |  |  |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|  | 10e. Street and Number<br>5333 South West 11th Place   |  |   |  | 10f. Zip Code<br>33914   |  | 10g. Citizen of What Country?<br>USA   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12 College (1-4 or 5+)  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Receptionist  |  |  | 16b. Kind of Business/Industry<br>Cemetery                       |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Leroy Goodfellow  |  |   |  | 18. Mother's Name (First, Middle, Maiden Summa)<br>Mary Jane Loger   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner                        | 19a. Informant's Name/Relationship (Type, Print)<br>William R. Dunlop/Husband  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5333 South West 11th Place Cape Coral, FL 33914   |  |  |  |  |  |
|  | 20e. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Metro Crematory, Inc.   |  | 20c. Location - City or Town, State<br>8/6/97 Baltimore, MD  |  |  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>Edward A. Gregorchik  |  |   |  | 22. Name and Address of Facility<br>Cremation Society of MD, Inc.<br>299 Frederick Rd Baltimore, MD 21228  |  |  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Biliary Sepsis<br>Due to (or as a consequence of):<br>b. Pancreatic Cancer<br>Due to (or as a consequence of):<br>c. COPD<br>Due to (or as a consequence of):<br>d. Lung Cancer |  |   |  |  |  |  |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  |   |  |  |  |  |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |
|  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  |  |  |  |  |  |  |
|  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)  |  |   |  |  |  |  |  |  |  |
|  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined  |  |   |  |  |  |  |  |  |  |
| State Registrar  | 28a. Date of Injury (Month, Day Year)  |  |   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  | 28d. Describe how injury occurred  |  |
|  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |  |  |  |  |
|  | 29b. Signature and title of certifier<br>R. Capone, MD   |  |   |  | 29c. License number<br>RES-000   |  | 29d. Date signed (Month, Day, Year)<br>8/5/97  |  |  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>R. Capone 655 Blalock, The Johns Hopkins Hospital  |  |   |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br>AUG 08 1997                     |  |  |   |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760, Baltimore, Maryland 21268-0760





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23965  
Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

Funeral  
Director

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>Rosa B. Duncan</b>  |  | 2. Date of Death<br>Month <b>July</b> Day <b>31</b> Year <b>97</b>   |  | 3. Time of Death<br><b>1547</b>  |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>Sinai Hospital</b>  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>n/a</b>  |  |
| 5. Social Security Number<br><b>225-20-1092</b>  |  | 6. Sex<br>1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>71</b> Yrs.   |  |
| 8. Date of Birth (Month, Day, Year)<br><b>Nov. 26, 1925</b>  |  | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |  |  |  |
| Usual Residence of Decedent  |  | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>n/a</b>  |  |
| 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  |  |  |
| 10e. Street and Number<br><b>3812 Ridgewood Ave.</b>   |  | 10f. Zip Code<br><b>21215</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |
| 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>9th</b> College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Fork Lift Operator</b>   |  |
| 16b. Kind of Business/Industry<br><b>Continental Can</b>   |  | 17. Father's Name (First, Middle, Last)<br><b>John J. Bellamy</b>  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Mamie Watson</b>   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>Wyndham Duncan/husband</b>  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3812 Ridgewood Ave. Balto., MD 21215</b>   |  |  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Arlington National</b>  |  | 20c. Location - City or Town, State<br><b>8/7 Arlington, VA</b>  |  |
| 21. Signature of Funeral Service Licensee<br><b>James A. Morton</b>  |  | 22. Name and Address of Facility<br><b>James A. Morton &amp; Sons Funeral Home<br/>1701 Laurens St. Balto., MD 21217</b>   |  |  |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>Acute GASTRO INTESTINAL BLEEDING</b><br><b>PEPTIC DISEASE</b>                        |  |  |  |  |  |
| 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>PAN ATHEROSCLEROTIC VASCULAR DISEASE</b><br><b>DIABETES MELLITUS</b><br><b>OSTEOARTHRITIS ANKLE</b>  |  |  |  |  |  |
| 23c. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |  |  |  |  |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide            |  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |  |
| 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  |  |  |
| 29b. Signature and title of certifier<br><b>Melva J. Brown M.D.</b>  |  | 29c. License number<br><b>125995</b>   |  | 29d. Date signed (Month, Day, Year)<br><b>8-5-97</b>   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Melva Brown M.D. Wyman Park Medical Center</b>  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>  |  | 32. Registrar's Signature<br><b>Julia Wilson-Randall</b>   |  |  |  |

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit



State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23966

## Certificate of Death

Reg. No.

|   |   |                                  |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|---|---|----------------------------------|---|------------------------|--|---|--|---|---|----|------------------------|--|----------------------------------|--|----|----------------------------------|----|----------------------------------|----|----------------------------------|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>VIRGINIA LEE DENNIS                   |                                  |   |                        | 2. Date of Death<br>Month Day Year<br>AUG 04 1997  |   | 3. Time of Death<br>8:08 PM  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   | 4e. Facility Name (If not institution, give street and number)<br>20 HAZEL AVENUE |                                  |   |                        | 4b. City, Town, or Location of Death<br>BALTIMORE  |   | 4c. County of Death<br>BALTIMORE   |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| Funeral<br>Director   | 5. Social Security Number<br>214-38-1934  |                                  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |                        | 7. Age (In yrs. last birthday)<br>56 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>AUG 26 1940   |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   | 10a. State<br>MD  |                                  | 10b. County<br>BALTIMORE  |                        | 10c. City, Town or Location<br>LANSDOWNE   |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| Usual Residence of Decedent   |   |                                  |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 10e. Street and Number<br>20 HAZEL AVENUE   |   |                                  |   | 10f. Zip Code<br>21227 |  | 10g. Citizen of What Country?<br>U.S.A.     |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   |                                  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |                        | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 8 College (1-4 or 5+)  |   |                                  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>MANAGER  |                        |  | 16b. Kind of Business/Industry<br>WAREHOUSE |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 17. Father's Name (First, Middle, Last)<br>HENRY C. SPARROW   |   |                                  |   |                        | 18. Mother's Name (First, Middle, Maiden Surname)<br>IRMA M. VOLKERT   |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br>DENISE A. HARANT (DAUGHTER)   |   |                                  |   |                        | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>167 STAFFORD ST, BALTIMORE, MD 21227  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |   |                                  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>LOUDON PARK CEMETERY  |                        | Data<br>8/09/97  |   | 20c. Location - City or Town, State<br>BALTIMORE, MD   |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 21. Signature of Funeral Service Licensee<br><i>Jackie R. Shannon</i>   |   |                                  |   |                        | 22. Name and Address of Facility<br>HUBBARD FUNERAL HOME, INC.<br>4107 WILKENS AVENUE, BALTIMORE, MD 21229   |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 23a. Pertinent disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |   |                                  |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>e.</td> <td>metastatic lung cancer</td> <td rowspan="4">           Approximate Interval Between Onset and Death<br/><br/>           3 mos.         </td> </tr> <tr> <td colspan="2">Due to (or as a consequence of):</td> </tr> <tr> <td>b.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>c.</td> <td>Due to (or as a consequence of):</td> </tr> <tr> <td>d.</td> <td>Due to (or as a consequence of):</td> <td></td> </tr> </table> |   |                                  |   |                        |  |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | e. | metastatic lung cancer | Approximate Interval Between Onset and Death<br><br>3 mos. | Due to (or as a consequence of): |  | b. | Due to (or as a consequence of): | c. | Due to (or as a consequence of): | d. | Due to (or as a consequence of): |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | e.  | metastatic lung cancer           | Approximate Interval Between Onset and Death<br><br>3 mos.  |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   | Due to (or as a consequence of):  |                                  |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   | b.  | Due to (or as a consequence of): |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   | c.  | Due to (or as a consequence of): |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| d.  | Due to (or as a consequence of):  |                                  |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |                                  |   |                        |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   |   |                                  |   |                        |  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   |   |                                  |   |                        |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify) |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |   |                                  | 28a. Date of Injury (Month, Day, Year)  |                        | 28b. Time of Injury<br>M   |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
|   |   |                                  | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |                        |  | 28d. Describe how injury occurred           |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |                                  | 29b. Signature and title of certifier<br><i>Yvonne Ottaviano MD</i>   |                        |  | 29c. License number<br>D40850               |  | 29d. Date signed (Month, Day, Year)<br>August 5, 1997 |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>YVONNE OTTAVIANO MD 900 CATON AVE BALTIMORE MD 21229  |   |                                  |   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |
| 31. Date filed (Month, Day, Year)<br>AUG 08 1997  |   |                                  | 32. Registrar's Signature<br><i>J. M. [Signature]</i>   |                        |  |   |  |   |   |    |                        |  |                                  |  |    |                                  |    |                                  |    |                                  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23967

## Certificate of Death

Reg. No.

|  |  |  |   |  |  |  |   |  |  |  |
|--|--|--|---|--|--|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><i>Alan dious F. Feldman</i>   |  |   |  |  |  | 2. Date of Death<br>Month <i>August</i> Day <i>5</i> Year <i>1997</i>   |  | 3. Time of Death<br><i>10:55AM</i>   |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><i>Sinai Hospital &amp; Baltimore</i>  |  |   |  |  |  | 4b. City, Town, or Location of Death<br><i>Baltimore</i>  |  | 4c. County of Death<br><i>Baltimore</i>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><i>217-54-3595</i>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><i>47</i> Yrs.   |  | If Under 1 Year<br>Months Days  |  | 8. Date of Birth (Month, Day, Year)<br><i>11-2-1949</i>  |  |
|  | Usual Residence of Decedent  |  | 10a. State<br><i>Md</i>   |  | 10b. County<br><i>NA</i>   |  | 10c. City, Town or Location<br><i>Baltimore</i>   |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
| To Be Completed by Funeral Director  | 10e. Street and Number<br><i>2648 Park Heights Terrace</i>   |  |   |  |  |  | 10f. Zip Code<br><i>21215</i>   |  | 10g. Citizen of What Country?<br><i>U.S.A</i>  |  |
|  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <i>Black</i>   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br><i>11th grade</i>  |  | College (1-4 or 5+)<br><i>NA</i>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><i>Maintenance</i>  |  | 16b. Kind of Business/Industry<br><i>Baltimore City</i>   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><i>Edward F. Blount</i>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><i>Lavern E. Feldman</i>   |  |  |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><i>Nathaniel Rantin - Father</i>   |  |   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>21133 8819 Liberty Road Randallstown, Md</i> |  |  |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><i>Garrison Forest Vet</i>  |  | Date<br><i>8-11-97</i>   |  | 20c. Location - City or Town, State<br><i>Owings Mills, Md</i>  |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br><i>Bladys Wamers</i>  |  |   |  |  |  | 22. Name and Address of Facility<br><i>March F.H. West 4300 Wabash Avenue Balt, Md 21215</i>  |  |  |  |
|  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><i>a. Intracranial Hemorrhage</i><br>Due to (or as a consequence of):<br><i>b. Cerebral Herniation</i><br>Due to (or as a consequence of):<br><br>Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><i>c.</i><br>Due to (or as a consequence of):<br><i>d.</i><br>Due to (or as a consequence of): |  |   |  |  |  |   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |  |   |  |  |  |   |  |  |  |
|  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown   |  |   |  |  |  |   |  |  |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |  |   |  |  |  |   |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |  |   |  |  |  |   |  |  |  |
| Medical Certification: To Be Completed by Physician/Medical Examiner   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |  |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><i>M</i>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
|  |  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |  |
|  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |  |  |   |  |  |  |
|  | 29b. Signature and title of certifier<br><i>[Signature] MD</i>   |  |   |  |  |  | 29c. License number<br><i>AS2402321-TO-9528</i>   |  | 29d. Date signed (Month, Day, Year)<br><i>August, 5, 1997</i>                                  |  |
| State Registrar  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><i>Troy Oberman 4501 W. Belvedere Ave. Baltimore, MD 21215</i>   |  |   |  |  |  |   |  |  |  |
|  | 31. Date filed (Month, Day, Year)<br><i>AUG 08 1997</i>  |  | 32. Registrar's Signature<br><i>Julia Davidson-Randall</i>  |  |  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 97 23968

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Freeman, George

2. Date of Death

Month

Day

Year

3. Time of Death

8:23 am

4a. Facility Name (If not institution, give street and number)

University of Maryland Hospital

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

217-03-9441

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

82 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

Feb. 21, 1915

9. Birthplace (State or Foreign Country)

Virginia

Usual Residence of Decedent

10a. State

Md.

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

1010 W. Baltimore Street

10f. Zip Code

21223

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ No  
If Yes, Give Year or Dates: 1-3-44  
4-24-46

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

To Be Completed by Physician/Medical Examiner

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12) 9th grade College (1-4 or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

TRUCK DRIVER / RIGGING

16b. Kind of Business/Industry

Foster Transfer Riggings

17. Father's Name (First, Middle, Last)

Preston Freeman

18. Mother's Name (First, Middle, Maiden Surname)

Mary Freeman

19a. Informant's Name/Relationship (Type, Print)

Barbara C. Freeman

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2005 W. Baltimore Street, Baltimore, Maryland 21217

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Garrison Forest Cemetery

Date

8-7-97

20c. Location - City or Town, State

Cwings Mills, Maryland

21. Signature of Funeral Service Licensee

J. Blount

22. Name and Address of Facility

Joseph H. Brown Jr. Funeral Home, PA.  
2140 N. Fulton Avenue, Baltimore, Maryland 21217

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. cardiac arrest / bradycardia

Approximate Interval Between Onset and Death

10-15 min

Due to (or as a consequence of):

b. gastrointestinal hemorrhage

Due to (or as a consequence of):

c. hypotension

Due to (or as a consequence of):

d. acute myocardial infarction

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

M

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, term, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert L. Rogers M.D.

29c. License number

9324

29d. Date signed (Month, Day, Year)

8/7/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

ROBERT L. ROGERS, M.D., UNIVERSITY HOSPITAL, 22 S. GREENE ST., BALTO. MD. 21201

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Julia Davidson

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 2 should be detached for use as the burial-transit certificate.

2+

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23969

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

LOUISE ESTELLE FLOWERS

2. Date of Death

08 06 97

3. Time of Death

6:35am

4a. Facility Name (If not institution, give street and number)

LORIEN Riverside

4b. City, Town, or Location of Death

Riverside

4c. County of Death

Harford

Funeral  
Director

5. Social Security Number

215-03-4797

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

88

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT 27, 1908

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

MD.

10b. County

Baltimore

10c. City, Town or Location

TOWSON

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

42 E. BURKE Ave

10f. Zip Code

21204

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

3

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Secretary

16b. Kind of Business/Industry

LEGAL

17. Father's Name (First, Middle, Last)

FRANCIS A. PHELPS

18. Mother's Name (First, Middle, Maiden Surname)

BLANCHE A. BIRKEY

19a. Informant's Name/Relationship (Type, Print)

PATRICIA DAWSON/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3008 HOUCKS MILL RD MONKTON, MD. 21111

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

DULANEY Valley Memorial Gdn

Date

Aug 7  
1997

20c. Location - City or Town, State

Timonium, Md

21. Signature of Funeral Service Licensee

► Robert W. Quach

22. Name and Address of Facility

Evans Funeral Chapel Bel Air 3 New Port Dr

Forest Hill Md

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a.

DEMENTIA

Due to (or as a consequence of):

b.

MALNUTRITION

Due to (or as a consequence of):

c.

RECURRENT INFECTIONS

Due to (or as a consequence of):

d.

Approximate  
Interval Between  
Onset and Death

&gt; 5 yrs

few years

few months

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

SEIZURE DISORDER

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

► Claudia Knoch

29c. License number

D500 40

29d. Date signed (Month, Day, Year)

August 6<sup>th</sup> 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

1308 BUSINESS CENTER WAY, SUITE 102, EDGEWOOD, MD 21040

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

John A. Wilson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23970

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>MINNIE MAY GRIMES  |  |   |  | 2. Date of Death<br>Month Day Year<br>AUGUST 2, 1997   |  | 3. Time of Death<br>11:27 PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>MARINER HEALTH OF KENSINGTON   |  |   |  | 4b. City, Town, or Location of Death<br>KENSINGTON   |  | 4c. County of Death<br>MONTGOMERY  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>218 24 6927   |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>99 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>APRIL 23, 1898                                |  |
|   | 9. Birthplace (State or Foreign Country)<br>MARYLAND   |  | 10a. State<br>MD.   |  | 10b. County<br>MONTGOMERY  |  | 10c. City, Town or Location<br>GERMANTOWN  |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>19509 FREDERICK ROAD  |  | 10f. Zip Code<br>20876   |  | 10g. Citizen of What Country?<br>UNITED STATES                                       |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No)<br>If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:      |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE                     |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 4 College (1-4 or 5+) 0   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>HOMEMAKER  |  | 16b. Kind of Business/Industry<br>OWN HOME   |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br>JAMES GRAY  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>MINNIE MAYHUGH  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 19a. Informant's Name/Relationship (Type, Print)<br>ROBERT GRIMES, SR. SON   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>19509 FREDERICK ROAD, GERMANTOWN, MD. 20876   |  |  |  |
|   | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>ARLINGTON NATIONAL  |  | Date<br>8/8/97   |  | 20c. Location - City or Town, State<br>ARLINGTON, VIRGINIA                           |  |
| To Be Completed by Physician/Medical Examiner | 21. Signature of Funeral Service Licensee<br>Muriel H. Barber  |  |   |  | 22. Name and Address of Facility<br>MURIEL H. BARBER FUNERAL HOME<br>P.O. BOX 5038, LAYTONSVILLE, MD. 20882  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. CONGESTIVE HEART FAILURE<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  | Approximate Interval Between Onset and Death<br>YEARS  |  |  |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>DEMENTIA<br>OSTEOMALACIA & VITAMIN D DEFICIENCY<br>HYPOTHYROIDISM  |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |  |  |  |
|   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  |  |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 28. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |  |  |  |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |  | 28e. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |  |
|   | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |   |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner | 29b. Signature and title of certifier<br>John J. Merendino Jr.   |  |   |  | 29c. License number<br>D36046  |  | 29d. Date signed (Month, Day, Year)<br>AUGUST 4, 1997                                |  |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>JOHN J. MERENDINO JR., MD 4701 RANDOLPH RD #216 ROCKVILLE, MD 20852  |  |   |  |  |  |  |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>AUG 08 1997   |  | 32. Registrar's Signature<br>Julia Davidson   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23971

## Certificate of Death

Reg. No.

|   |  |   |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|---|--|---|--|--|---|--|---|--|---|---|----|--|-------------------|----|---|-------------------|----|--|--|----|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Oliver R. Garnes</b>  |   |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>3</b> Year <b>1997</b> |  |   |  | 3. Time of Death<br><b>12:54</b>                      |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>University of Maryland Medical System</b> |   |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore, MD</b>          |  |   |  | 4c. County of Death<br><b>Baltimore City</b>          |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>216-28-4831</b>  |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (In yrs. last birthday)<br><b>66</b> Yrs.                      |  | 8. Date of Birth<br>(Month, Day, Year)<br><b>12-31-30</b>               |  | 9. Birthplace (State or Foreign Country)<br><b>VA</b> |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   | Usual Residence of Decedent  |   |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 10a. State<br><b>Md.</b>  |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |   |  |   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 10e. Street and Number<br><b>5205 Moravia Road Apt "B"</b>  |  |   |  | 10f. Zip Code<br><b>21206</b>  |   | 10g. Citizen of What Country?<br><b>USA</b>                                      |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b> |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>NA</b>  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Driver Truck</b>   |   |  | 16b. Kind of Business/Industry<br><b>various facilities</b>             |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 17. Father's Name (First, Middle, Last)<br><b>Belgian Herman</b>  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Elnora Chambliss</b>   |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>James Bostic</b>   |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21214</b><br><b>4707 Pilgrim Road Baltimore, Maryland</b>                                   |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cem 08-11-97 Owings Mills,</b>   |   | 20c. Location - City or Town, State<br><b>Md.</b>                                |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202</b><br><b>WM.C. March FH 1101 E. North Avenue</b>   |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  |  |   |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| <table border="0"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last         </td> <td>a.</td> <td><b>hypoxia</b><br/>Due to (or as a consequence of):</td> <td><b>55 minutes</b></td> </tr> <tr> <td>b.</td> <td><b>respiratory arrest</b><br/>Due to (or as a consequence of):</td> <td><b>55 minutes</b></td> </tr> <tr> <td>c.</td> <td><b>chronic obstructive pulmonary disease</b><br/>Due to (or as a consequence of):</td> <td></td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table> |  |   |  |  |   |  |   |  |   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | a. | <b>hypoxia</b><br>Due to (or as a consequence of): | <b>55 minutes</b> | b. | <b>respiratory arrest</b><br>Due to (or as a consequence of): | <b>55 minutes</b> | c. | <b>chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of): |  | d. |  |  |
| Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last   | a.   | <b>hypoxia</b><br>Due to (or as a consequence of):  | <b>55 minutes</b>  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   | b.   | <b>respiratory arrest</b><br>Due to (or as a consequence of):   | <b>55 minutes</b>  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   | c.   | <b>chronic obstructive pulmonary disease</b><br>Due to (or as a consequence of):  |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   | d.   |   |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>slp thoracic aneurysm repair</b>   |  |   |  |  |   |  |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   |  |   |  |  |   |  |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   |  |   |  |  |   |  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input checked="" type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   | 28d. Describe how Injury occurred  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
|   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  |  |   | 28f. Location (Street and Number or Rural Route Number, City or Town, State)     |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |  |   |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 29b. Signature and title of certifier<br>   |  |   |  | 29c. License number<br><b>P10360</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>August 3, 1997</b>                     |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>MICHAEL J. SOSTAK Dept of Surgery University of Maryland Medical System Baltimore, Maryland</b>  |  |   |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |  | 32. Registrar's Signature<br>   |  |  |   |  |   |  |   |   |    |  |                   |    |   |                   |    |  |  |    |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

10th Grade

NA

Driver Truck

Belgian

Herman

Elmore

Chambless

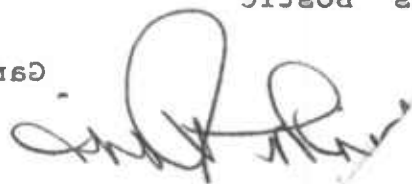
James Bostic

4707 Pilgrim Road Baltimore, Maryland

Garrison Forest VA Cem 08-11-97 Owinga W

Baltimore, Maryland

WM.C. March FH 1101 E. North Aven



X

X

X

X

X

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23972

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

ANNIE M. GREEN

2. Date of Death

August 5 1997

3. Time of Death

2:30 pm

4a. Facility Name (If not institution, give street and number)

LIBERTY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

CITY

Funeral  
Director

5. Social Security Number

214-38-8742

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

79 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

SEPT. 17, 1917

9. Birthplace (State or Foreign Country)

NORTH CAROLINA

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2927 WINCHESTER STREET

10f. Zip Code

21216

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?

1 ☐ Yes 2 ☐ No

If Yes, Give X Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: NEGRO

15. Decedent's Education

(Specify only highest grade completed)

Elementary/Secondary (0-12)

9TH

College (1-4or 5+)

N/A

16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired)

DOMESTIC

16b. Kind of Business/Industry

PRIVATE HOME

17. Father's Name (First, Middle, Last)

ROBERT LATTA

18. Mother's Name (First, Middle, Maiden Surname)

MISSOURI SPEED

19a. Informant's Name/Relationship (Type, Print)

LINDA M. GREEN- DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2927 WINCHESTER STREET BALTIMORE, MD. 21216

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

MT. ZION CEMETERY Aug. 9, 1997

Date

20c. Location - City or Town, State

BALTIMORE, MARYLAND

21. Signature of Funeral Service Licensee

Calvin B. Scruggs, Jr.

22. Name and Address of Facility

CALVIN B. SCRUGGS FUNERAL HOME

1412 E. PRESTON ST. BALTO, MD. 21213

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. PULMONARY EMBOLISM

Due to (or as a consequence of):

b. LEFT ATRIAL VEIN THROMBOSIS

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Approximate Interval Between Onset and Death

5 days

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RETROPERITONEAL ABSCESS - MULTIPLE

DECUBITUS ULCERS - ALBINO. MALNUTRITION

DIABETES MELLITUS - PLEURAL EFFUSION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

[Signature]

29c. License number

D19057

29d. Date signed (Month, Day, Year)

August, 5, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RELYA E. CORREA MD

LIBERTY MEDICAL CENTER

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

T

State  
Registrar





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23973

## Certificate of Death

Reg. No.

|  |  |   |   |   |  |  |   |  |
|--|--|---|---|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>Margaret Evelyn Goetz</b>   |   |   |   | 2. Date of Death<br>Month Day Year<br><b>August 5 1997</b>   |  | 3. Time of Death<br><b>7:25 am</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>Stella Maris Hospice</b>  |   |   |   | 4b. City, Town, or Location of Death<br><b>Towson</b>  |  | 4c. County of Death<br><b>Baltimore</b>   |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>217-26-8158</b>  |   | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F  |   | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>March 19, 1930</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>  |   | 10a. State<br><b>Md.</b>  |   | 10b. County<br><b>Baltimore</b>  |  | 10c. City, Town or Location<br><b>Essex</b>   |  |
| To Be Completed by Funeral Director  | Usual Residence of Decedent  |   | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 10e. Street and Number<br><b>334 Montrose Ave.</b>   |  | 10f. Zip Code<br><b>21221</b>   |  |
|  | 10g. Citizen of What Country?<br><b>USA</b>  |   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  |
|  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+)  |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Housewife</b>  |  | 16b. Kind of Business/Industry<br><b>own home</b>   |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>Anthony Carbone</b>  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Genevieve Smith</b>   |   | 19a. Informant's Name/Relationship (Type, Print)<br><b>L. Thomas Goetz/husband</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>334 Montrose Ave. Baltimore MD. 21221</b>   |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cemetery</b>  |   | 20c. Date<br><b>8/8/97</b>   |  | 20d. Location - City or Town, State<br><b>Owings Mills MD</b>   |  |
|  | 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>  |   | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>   |   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. END Stage Dementia</b><br>Due to (or as a consequence of):<br><b>Parkinson's</b><br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  | Approximate Interval Between Onset and Death  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown  |   | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |
|  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)  |  |
|  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   | 28d. Describe how injury occurred  |  | 28e. Location (Street and Number or Rural Route Number, City or Town, State)  |  |
|  | 29a. Certifier (Check only one)<br>1 <input type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |   | 29c. License number<br><b>D 15504</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>8-5-97</b>  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>Eddie Nakhuda, M.D. 2300 Dulaney Valley Rd Timonium, Md 21093</b> |  | 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b> |   | 32. Registrar's Signature<br><b>[Signature]</b> |  |  |   |  |

NAME: MARGARET GOETZ

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Division of Vital Records, P.O. Box 68760,

NAME: MARGARET GOETZ

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23974

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br><b>Mark T Harvey</b>  |  |  |  | 2. Date of Death<br>Month <b>August</b> Day <b>5</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>11:37 AM</b>   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>UNIVERSITY OF MARYLAND MEDICAL SYSTEMS</b>   |  |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>   |  |
| Funeral<br>Director                           | 5. Social Security Number<br><b>214-86-0057</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |  | 7. Age (in yrs. last birthday)<br><b>33</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>December 24, 1963</b>   |  |
|   | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b>   |  | 10a. State<br><b>md.</b>   |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  | 10e. Street and Number<br><b>2735 Giles Road</b>   |  | 10f. Zip Code<br><b>21225</b>   |  |
|   | 10g. Citizen of What Country?<br><b>USA</b>   |  |  |  | 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  |
| To Be Completed by Physician/Medical Examiner | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  |  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>  |  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th grade</b> College (1-4 or 5+)              |  |
|   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Cook</b>  |  |  |  | 16b. Kind of Business/Industry<br><b>Gampys</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 17. Father's Name (First, Middle, Last)<br><b>Theodore Cotton</b>   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Ruth Harvey</b>  |  |   |  |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Ruth McHaurin (mother)</b>   |  |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2735 Giles Road, Baltimore, Maryland</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>St. Zion Cemetery</b>   |  |   |  |
|   | 20c. Location - City or Town, State<br><b>8-8-97 Lansdowne Maryland</b>   |  |  |  | 21. Signature of Funeral Service Licensee<br><b>Joseph H. Brown Jr.</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 22. Name and Address of Facility<br><b>Joseph H. Brown Jr. Funeral Home, PA.<br/>2140 N. Fulton Avenue, Baltimore, Maryland 21217</b>   |  |  |  | 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |  |   |  |
|   | Immediate Cause (Final disease or condition resulting in death)<br><b>Pneumonia</b><br>Due to (or as a consequence of):<br><b>AIDS</b><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>5 years</b>  |  |  |  | Approximate Interval Between Onset and Death<br><b>2 days</b>  |  |   |  |
| To Be Completed by Physician/Medical Examiner | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown   |  |   |  |
|   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |   |  |
| To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  |  |  | 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  |  |   |  |
|   | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined  |  |  |  | 28a. Date of Injury (Month, Day Year)<br><b>M</b><br>28b. Time of injury<br><b>11:37 AM</b><br>28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No<br>28d. Describe how injury occurred<br><b>28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)</b><br><b>28f. Location (Street and Number or Rural Route Number, City or Town, State)</b> |  |   |  |
| To Be Completed by Physician/Medical Examiner | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |  |  | 29b. Signature and title of certifier<br><b>Scott Huber MD</b>   |  |   |  |
|   | 29c. License number<br><b>P09738</b>  |  |  |  | 29d. Date signed (Month, Day, Year)<br><b>8/7/97</b>   |  |   |  |
| To Be Completed by Physician/Medical Examiner | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>Scott Huber MD 22 S. Green St Baltimore, MD 21201</b>  |  |  |  | 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>  |  |   |  |
|   | 32. Registrar's Signature<br><b>Julia Davidson-Randall</b>  |  |  |  |  |  |   |  |



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State of Maryland / Department of Health and Mental Hygiene

97 23975

Items: 4a, 10e per MD G-750 8/8/97.dh.

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Charles Peter Harbaugh, Jr.

2. Date of Death

June 29, 1997

3. Time of Death

4 AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

2513 Girdwood Road

4b. City, Town, or Location of Death

Timonium

4c. County of Death

Timonium

5. Social Security Number

215-18-3467

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

77

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)  
July 23, 1919

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

Timonium

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2513 Girdwood Road

10f. Zip Code

21093

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 1941-45

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
4

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Engineer

16b. Kind of Business/Industry

Machine Tool

17. Father's Name (First, Middle, Last)

Charles Peter Harbaugh, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Mary Ellen Cunahan

19a. Informant's Name/Relationship (Type, Print)

Rose A. Harbaugh/wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2513 Girdwood Road, Timonium, Maryland 21093

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☒ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Data

20c. Location - City or Town, State

21. Signature of Funeral Service Licensee

Ronald S. Wade, Director

22. Name and Address of Facility

State Anatomy Board, 655 W. Baltimore Street  
Baltimore, Maryland 21201

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. RECURRENT AND METASTATIC ADENOCARCINOMA

15 months

Due to (or as a consequence of): OF ESOPHAGUS

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. ADENOCARCINOMA DISTAL ESOPHAGUS

33 months

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

MALNUTRITION

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☒ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

John N. Saunders MD

29c. License number

D28133

29d. Date signed (Month, Day, Year)

7-7-97

30. Name and Address of person who completed cause of death (Item 23a) (Type, Print)

John R. Saunders 6569 N. CHARLES ST #200 BALTIMORE MD 21204

State  
Registrar

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Julia Davidson-Randall

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23976

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

JOHN GROVER CLEVELAND HAYDEN

2. Date of Death  
Month Day Year

AUG

06

1997

3. Time of Death

3:20 am

4a. Facility Name (If not institution, give street and number)

Villa St. Michael 4800 Seton Drive

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Balt City

Funeral  
Director

5. Social Security Number

214-61-2218

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

89 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth  
(Month, Day, Year)

JAN 27 1908

9. Birthplace (State or Foreign Country)

KENTUCKY

Usual Residence of Decedent

10a. State

MARYLAND

10b. County

N/A

10c. City, Town or Location

BALTIMORE CITY

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

3925 MORTIMER AVENUE

10f. Zip Code

21215

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☒ Yes 2 ☐ No

If Yes, Give Year or Dates: 43/45

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

10th grade

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working life. DO NOT use retired)

STOCK CLERK

16b. Kind of Business/Industry

GOVERNMENT

17. Father's Name (First, Middle, Last)

JAMES HAYDEN

18. Mother's Name (First, Middle, Maiden Surname)

JULIA HAYDEN

19a. Informant's Name/Relationship (Type, Print)

Virgiel Hayden/ Daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3925 Mortimer Avenue, Baltimore Maryland 21215

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

GARRISON FOREST

Date

8-12-97

20c. Location - City or Town, State

OWINGS MILLS, MARYLAND

21. Signature of Funeral Service Licensee

Hani G. Clave

22. Name and Address of Facility

WILLIAM C. BROWN COMMUNITY F/H  
1206 W. NORTH AVENUE

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate  
Interval Between  
Onset and Death

Immediate Cause (Final disease or condition resulting in death)

e. metastatic disease to the lungs

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Cecal mass (adenocarcinoma)

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined28a. Date of Injury  
(Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier  
(Check only one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Wanda J. Clemmons, MD

29c. License number

D35674

29d. Date signed (Month, Day, Year)

August 7, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Wanda J. Clemmons, MD

4820 Seton Drive, Suite A, Balt MD 21215

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T

3





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State of Maryland / Department of Health and Mental Hygiene 97 23977

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |   |  |
|---|--|--|---|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Robert Hagelgans   |  |   |  | 2. Date of Death<br>Month Day Year<br>August 2, 1997   |  | 3. Time of Death<br>4:30 AM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>VA MHCS Fort Howard Division   |  |   |  | 4b. City, Town, or Location of Death<br>Ft. Howard   |  | 4c. County of Death<br>Baltimore  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>202-16-4821   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>73 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>June 2, 1924   |  |
|   | 9. Birthplace (State or Foreign Country)<br>PA.  |  | 10a. State<br>PA  |  | 10b. County<br>Carbon  |  | 10c. City, Town or Location<br>Hazelton   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>639 Carson Street   |  | 10f. Zip Code<br>18201   |  | 10g. Citizen of What Country?<br>USA  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 12th<br>College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>USARMY   |  | 16b. Kind of Business/Industry<br>USARMY   |  | 17. Father's Name (First, Middle, Last)<br>William J. HAGelgans   |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Bridget Lavelle   |  | 19a. Informant's Name/Relationship (Type, Print)<br>Alverna Hagelgans/wife  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>639 Carson Street Hazelton PA.  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Indiantown Gap National  |  | 20c. Date<br>8/5/97   |  | 20d. Location - City or Town, State<br>Annville PA.  |  | 21. Signature of Funeral Service Licensee<br>R. Terry Connelly  |  |
|   | 22. Name and Address of Facility<br>Connelly Funeral Home of Essex<br>300 Mace Ave. Baltimore Md. 21221  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>a. Hepatic Cirrhosis Secondary to Alcohol 5 yrs.<br>Due to (or as a consequence of):<br>b. Hepatocellular Carcinoma 3 Mos.<br>Due to (or as a consequence of):<br>c. S/P Head & Neck Dissection for Squamous Cell 5 Yrs.<br>Due to (or as a consequence of):<br>d. Carcinoma |  | Approximate Interval Between Onset and Death   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of Injury (Month, Day Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred  |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br>J. B. Smith   |  | 29c. License number<br>D 30528  |  | 29d. Date signed (Month, Day, Year)<br>Aug 2nd 1997  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br>Bala Duggirala, MD 9600 North Point Road, Fort Howard, MD 21052   |  |
| To Be Completed by Physician/Medical Examiner | 31. Date filed (Month, Day, Year)<br>AUG 08 1997   |  | 32. Registrar's Signature<br>J. B. Smith  |  | 33. Registrar's Title<br>Registrar   |  | 34. Registrar's Date<br>AUG 08 1997   |  |
|   | 35. Registrar's Signature<br>J. B. Smith   |  | 36. Registrar's Title<br>Registrar  |  | 37. Registrar's Date<br>AUG 08 1997  |  | 38. Registrar's Signature<br>J. B. Smith  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

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97-4339-510

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GEORGE

JOHNSON

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23978

## Certificate of Death

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. Decedent's Name (First, Middle, Last)<br><b>George P. Johnson</b>  |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>4</b> Year <b>1997</b>  |  | 3. Time of Death<br><b>144p</b>   |  |
| 4a. Facility Name (If not institution, give street and number)<br><b>11 W. 20th STREET. 11D</b>   |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |  | 4c. County of Death<br><b>NA</b>  |  |
| 5. Social Security Number<br><b>212-36-7401</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>59</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>07-28-38</b>  |  |
| 9. Birthplace (State or Foreign Country)<br><b>MD.</b>  |  | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>NA</b>   |  | 10c. City, Town or Location<br><b>Baltimore</b>   |  |
| 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  | 10e. Street and Number<br><b>11 West 20th Street Apt. 11-D</b>  |  | 10f. Zip Code<br><b>21218</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>   |  |
| 11. Marital Status<br><input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th Grade</b><br>College (1-4 or 5+) <b>NA</b>   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Kitchen Helper</b>  |  | 16b. Kind of Business/Industry<br><b>Facilities</b>  |  | 17. Father's Name (First, Middle, Last)<br><b>Phat Johnson</b>  |  |
| 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Lee Thrower</b>  |  | 19a. Informant's Name/Relationship (Type, Print)<br><b>Gwendolyn Reid</b>   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>8722 Stockwell Road Baltimore, Maryland 21234</b>  |  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |  |
| 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Mt. Calvary Cem. 08-08-97</b>  |  | 20c. Location - City or Town, State<br><b>Anne Arundel Co, Md.</b>  |  | 21. Signature of Funeral Service Licensee<br><i>Theodore M. King</i>   |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202<br/>WM.C.March FH 1101 E. North Avenue</b>   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Hypertensive Arteriosclerotic Cardiovascular Disease</b><br>Due to (or as a consequence of):<br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |  |  |   |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input checked="" type="checkbox"/> Unknown  |  |   |  |  |  |   |  |
| 24a. Was an autopsy performed?<br><i>inspection</i><br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide<br><input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |  | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
| 29b. Signature and title of certifier<br><i>Theodore M. King</i>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>August 5, 1997</b>   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>THEODORE M. KING<br/>111 Penn Street, Baltimore, Maryland 21201</b>  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |  | 32. Registrar's Signature<br><i>John Davidson-Randall</i>   |  | 33. Registrar's Title<br><b>John Davidson-Randall</b>  |  | 34. Registrar's Office<br><b>John Davidson-Randall</b>  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item 23a or 23b show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23979

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

HELEN B. JACOBUS

2. Date of Death

Month Day Year  
July 31 1997

3. Time of Death

10:00AM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Charles town Care Center

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

152-42-5862

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

93

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
FEB 23 1904

9. Birthplace (State or Foreign Country)

NEW JERSEY

Usual Residence of Decedent

10a. State

MD

10b. County

BALTIMORE

10c. City, Town or Location

CATONSVILLE

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

709 MAIDEN CHOICE LANE, 117B

10f. Zip Code

21228

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: WHITE

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

HOMEMAKER

16b. Kind of Business/Industry

HOMEMAKING

17. Father's Name (First, Middle, Last)

JESSE BABCOOK

18. Mother's Name (First, Middle, Maiden Surname)

ELIZABETH SHARP

19a. Informant's Name/Relationship (Type, Print)

RALPH E. JACOBUS (SON)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7899 WEST HILL DRIVE FREDERICK, MD 21702

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

HOLLYWOOD CEMETERY

Date

8/11/97

20c. Location - City or Town, State

UNION, NEW JERSEY

21. Signature of Funeral Service Licensee

Jackie D. Shannon

22. Name and Address of Facility

HUBBARD FUNERAL HOME, INC.  
4107 WILKENS AVE, BALTIMORE, MD 2122923a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
stroke, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. Congestive Heart Failure

years

Due to (or as a consequence of):

b. Ischemic Heart Disease

years

Due to (or as a consequence of):

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation  
6 ☐ Could not be determined

28a. Date of Injury

(Month, Day Year)

28b. Time of injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Phillip Stone MD

29c. License number

D47009

29d. Date signed (Month, Day, Year)

July 31, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

711 Maiden Choice Lane, Baltimore, MD 21228

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Davidson-Rendell

State  
Registrar

Baltimore, Maryland 21215-0020

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 23a-4 show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

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State of Maryland / Department of Health and Mental Hygiene

97 23980

## Certificate of Death

Reg. No.

|  |   |   |  |   |  |  |   |  |
|--|---|---|--|---|--|--|---|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>William H. James Jr.</b>                       |   |  |   | 2. Date of Death<br>Month Day Year<br><b>Aug. 4 1997</b> |  | 3. Time of Death<br><b>10:53pm</b>                          |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>4A Glen Shanon Court</b> |   |  |   | 4b. City, Town, or Location of Death<br><b>Essex</b>     |  | 4c. County of Death<br><b>Baltimore</b>                     |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>035-18-7061</b>   |   | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F |   | 7. Age (In yrs. last birthday)<br><b>74</b> Yrs.         |  | 8. Date of Birth (Month, Day, Year)<br><b>Oct. 22, 1922</b> |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>R.I.</b>                                       |   | 10a. State<br><b>Md.</b>   |   | 10b. County<br><b>Baltimore</b>                          |  | 10c. City, Town or Location<br><b>Essex</b>                 |  |
| 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   | 10e. Street and Number<br><b>4A Glen Shanon Court</b>   |  | 10f. Zip Code<br><b>21221</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |   |  |
| 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>  |   |  |
| 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>4yrs</b>   |   | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Master Mariner</b>  |  | 16b. Kind of Business/Industry<br><b>Seaman</b>   |  |  |   |  |
| 17. Father's Name (First, Middle, Last)<br><b>unknown</b>  |   |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>unknown</b>   |  |  |   |  |
| 19a. Informant's Name/Relationship (Type, Print)<br><b>William James /son</b>  |   |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1568 Waff Road Virginia Beach VA. 23464</b>   |  |  |   |  |
| 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory Inc.</b>   |  | 20c. Date<br><b>8/7/97</b>  |  | 20d. Location - City or Town, State<br><b>Baltimore Md.</b>  |   |  |
| 21. Signature of Funeral Service Licensee<br><b>R. Terry Connelly</b>  |   |   |  | 22. Name and Address of Facility<br><b>Connelly Funeral Home of Essex<br/>300 Mace Ave. Baltimore Md. 21221</b>   |  |  |   |  |
| 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>e. SQUAMOUS CELL CARCINOMA OF TONGUE</b><br>Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. c. d.</b><br>Due to (or as a consequence of):<br>Due to (or as a consequence of):<br>Due to (or as a consequence of): |   |   |  | Approximate Interval Between Onset and Death<br><b>5 months</b>   |  |  |   |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE;<br/>EMPHYSEMA, DIABETES, ADULT ONSET;<br/>MELANOMA, LEFT FOREARM</b>   |   |   |  |   |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |   |  |
| 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  |   |  |  |   |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |  |   |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |   | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |
| 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |   | 28d. Describe how injury occurred   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |  |  |   |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Certifying Physician: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |   | 29b. Signature and title of certifier<br><b>[Signature]</b>   |  | 29c. License number<br><b>D18642</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>8/5/97</b>   |   |  |
| 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>S. PARGAMENT, MD 5518 B PHILADELPHIA RD. BALT, MD 21237</b>   |   |   |  |   |  |  |   |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>  |   |   |  | 32. Registrar's Signature<br><b>[Signature]</b>   |  |  |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

State  
Registrar





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

97 23981

Items: 10a-c, e, f, 17 per FH G-750 8/7/97 dh

Reg. No.

Physician  
/Medical  
ExaminerFuneral  
Director

1. Decedent's Name (First, Middle, Last)

BEATRICE JENKINS

2. Date of Death

Month  
07Day  
14Year  
97

3. Time of Death

11:50PM

4a. Facility Name (If not institution, give street and number)

COLLINGTON EPISCOPAL LIFE CENTER

4b. City, Town, or Location of Death

MITCHELLVILLE

4c. County of Death

PRINCE GEORGES

5. Social Security Number

578 32 6543

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

77

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
03 01 20

9. Birthplace (State or Foreign Country)

LAWRENCE, KANSAS

Usual Residence of Decedent

10a. State  
D.C.  
MD

10b. County

PRINCE GEORGES

10c. City, Town or Location

Washington  
MITCHELLVILLE

10d. Inside City Limits

XX Yes 2 ☐ No

10e. Street and Number

6321 14th. Street N.W.  
10450 LOTTSFORD RD.

10f. Zip Code

20011  
20721

10g. Citizen of What Country?

UNITED STATES

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: BLACK

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)  
12College (1-4 or 5+)  
5

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

SUPERVISOR (FEDERAL GOVT.)

16b. Kind of Business/Industry

NATIONAL SCIENCE FOUNDATION

17. Father's Name (First, Middle, Last)

UNKNOWN Joseph Edward Hughes

18. Mother's Name (First, Middle, Maiden Surname)

LETHNA HUGHES

19a. Informant's Name/Relationship (Type, Print)

CHERYL JENKINS SMITH/DAUGHTER

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7814-201 HANOVER PKWY., GREENBELT, MD 20770

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

HARMONY MEMORIAL PARK CEMETERY

20c. Location - City or Town, State

LANDOVER, MD.

21. Signature of Funeral Service Licensee

Juan Smith

22. Name and Address of Facility

JOHN T. RHINES COMPANY  
3030 12TH ST., NE WASHINGTON DC 20017

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CARCINOMA OF PANCREAS

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

Robert T. Dibble

29c. License number

D033 96

29d. Date signed (Month, Day, Year)

7/15/97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT T. DIBBLE, MD 106 IRVING ST NW, WASHINGTON, DC 20010 SUITE# 4200

31. Date filed (Month, Day, Year)

JUL 18 1997

32. Registrar's Signature

John A. R. R. R.

State  
Registrar

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit once.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23982

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

RUDOLPH A. KAZMAR

2. Date of Death

Month

Day

Year

August

6

1997

3. Time of Death

8:33 PM

4a. Facility Name (If not institution, give street and number)

SINAI HOSPITAL

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

N/A

Funeral  
Director

5. Social Security Number

116-28-9108

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

59

Yrs.

If Under 1 Year

Months

Days

If Under 24 Hrs.

Hours

Min.

8. Date of Birth

(Month, Day, Year)

June 9, 1938

9. Birthplace (State or Foreign Country)

Poland

Usual Residence of Decedent

10a. State

MD

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

5603 Narcissus Avenue

10f. Zip Code

21215

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☐ Widowed 4 ☒ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Hubert Kazmar

18. Mother's Name (First, Middle, Maiden Surname)

Ottilia Bugla

19a. Informant's Name/Relationship (Type, Print)

Lorrie L. Kazmar/daughter

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

703 Fern Valley Circle, Apt. 10 Catonsville, MD 21228

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Metro Crematory, Inc. 8/8/97

Date

20c. Location - City or Town, State

Baltimore, MD

21. Signature of Funeral Service Licensed

Dawn F. McDonald

22. Name and Address of Facility

Cremation Society of Maryland, Inc.  
299 Frederick Rd. Baltimore, MD 2122823a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

a. GASTROINTESTINAL BLEEDING

Due to (or as a consequence of):

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

26. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence 6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
2 ☐ Accident investigation  
3 ☐ Suicide 6 ☐ Could not be  
4 ☐ Homicide determined28a. Date of Injury  
(Month, Day, Year)28b. Time of  
Injury28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)2 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Albert J. ... MD

29c. License number

A52402321-AJ-9520 August 6, 1997

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ALBERT J. ... MD SINAI HOSPITAL, BALTIMORE, MD

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

John Davidson

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "Natural", or items 23a or 23b-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled out by the funeral director, page 2 should be detached for use as the burial-transit  
document.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23983

## Certificate of Death

Reg. No.

|   |  |                                 |   |  |  |                                |  |   |
|---|--|---------------------------------|---|--|--|--------------------------------|--|---|
| Physician<br>/Medical<br>Examiner                       | 1. Decedent's Name (First, Middle, Last)<br><b>IPA KERSHMAN</b>  |                                 |   |  | 2. Date of Death<br>Month <b>AUG</b> Day <b>6</b> Year <b>1997</b>   |                                | 3. Time of Death<br><b>9:33PM</b>  |   |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>NORTHWEST Hospital Center</b>   |                                 |   |  | 4b. City, Town, or Location of Death<br><b>RODALLSTOWN</b>   |                                | 4c. County of Death<br><b>BALTIMORE</b>  |   |
| Funeral<br>Director                                     | 5. Social Security Number<br><b>212-16-9484</b>  |                                 | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>90</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min. | 8. Date of Birth (Month, Day, Year)<br><b>AUG 2, 1907</b>                                      | 9. Birthplace (State or Foreign Country)<br><b>Maryland</b> |
|   | Usual Residence of Decedent  |                                 |   |  |  |                                |  |   |
| To Be Completed by Funeral Director                     | 10a. State<br><b>MD</b>  | 10b. County<br><b>Baltimore</b> |   | 10c. City, Town or Location<br><b>Baltimore</b>  |  |                                | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |
|   | 10e. Street and Number<br><b>7920 Scotts Level Road</b>  |                                 |   |  | 10f. Zip Code<br><b>21208</b>  |                                | 10g. Citizen of What Country?<br><b>USA</b>  |   |
|   | 11. Marital Status<br><input type="checkbox"/> Navar Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |                                 | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:   |                                | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b>                        |   |
|   | 15. Decedent's Education (Specify only highest grade completed)<br><b>Elementary/Secondary (0-12)</b>  |                                 | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Telephone Sales</b>               |  | 16b. Kind of Business/Industry<br><b>Pharmaceutical</b>  |                                |  |   |
|   | 17. Father's Name (First, Middle, Last)<br><b>William Berlin</b>   |                                 |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Rose Unknown</b>   |                                |  |   |
| To Be Completed by Physician/Medical Examiner           | 19a. Informant's Name/Relationship (Type, Print)<br><b>Allen Kershman/son</b>  |                                 |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>2720 Hanson Ave. Baltimore, MD 21209</b>   |                                |  |   |
|   | 20a. Method of Disposition<br><input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |                                 | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc. 8/7/97</b>                                     |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>  |                                |  |   |
|   | 21. Signature of Funeral Service Licensee<br><b>Dawn F. McDonald</b>   |                                 |   |  | 22. Name and Address of Facility<br><b>Cremation Society of Maryland, Inc.<br/>299 Frederick Rd. Baltimore, MD 21228</b>   |                                |  |   |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>a. MYOCARDIAL INFARCTION</b><br>Due to (or as a consequence of):   |                                 |   |  |  |                                |  |   |
|   | 23b. Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I.<br><b>b. c. d.</b><br>Due to (or as a consequence of):   |                                 |   |  |  |                                |  |   |
| Physician<br>/Medical<br>Examiner                       | 23a. Immediate Cause (Final disease or condition resulting in death)<br><b>a. MYOCARDIAL INFARCTION</b>  |                                 |   |  | 23b. Approximate Interval Between Onset and Death<br><b>One Hour</b>   |                                |  |   |
|   | 23c. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. c. d.</b>   |                                 |   |  |  |                                |  |   |
|   | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |                                 |   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |                                |  |   |
|   | 27. Manner of Death<br><input type="checkbox"/> Natural <input type="checkbox"/> Accidental <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined  |                                 | 28a. Date of Injury (Month, Day, Year)  |  | 28b. Time of Injury<br><b>M</b>  |                                | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No    |   |
|   | 28d. Describe how Injury occurred  |                                 | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |                                |  |   |
| State<br>Registrar                                      | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |                                 |   |  | 29b. Signature and title of certifier<br><b>[Signature]</b>  |                                | 29c. License number<br><b>15140</b>  |   |
|   | 29d. Date signed (Month, Day, Year)<br><b>8/7/97</b>   |                                 |   |  |  |                                |  |   |
|   | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>IPA SUNSHINE MD 6210 BACK HEIGHTS AVE, BAL, MD 21215</b>  |                                 |   |  |  |                                |  |   |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b> |  |                                 |   | 32. Registrar's Signature<br><b>[Signature]</b>  |  |                                |  |   |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23c show any injury or other traumatic event, the Medical Examiner must be notified at once.

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23984

ITEM: 31 per FH G-750 8-8-97 eoh

|   |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
|---|---|---------------------------------------|--|--|--|--|---|--|---|---------------------------------------|--|-----------------------------------|----|----|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Klaus Walter Karrasch</b>  |                                       |  |  | 2. Date of Death<br>Month Day Year<br><b>AUG 4, 1997</b>   |  | 3. Time of Death<br><b>11:13PM</b>                                      |  |   |                                       |  |                                   |    |    |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>Good Samaritan Hospital</b>  |                                       |  |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>N/A</b>                                       |  |   |                                       |  |                                   |    |    |
| Funeral<br>Director   | 5. Social Security Number<br><b>213-40-0319</b>   |                                       | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br><b>62</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>FEB 4, 1935</b>               |  |   |                                       |  |                                   |    |    |
|   | 9. Birthplace (State or Foreign Country)<br><b>Germany</b>  |                                       | 10a. State<br><b>MD</b>  |  | 10b. County<br><b>N/A</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>                         |  |   |                                       |  |                                   |    |    |
| To Be Completed by Funeral Director   | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |                                       | 10e. Street and Number<br><b>2106 Cloville Avenue</b>  |  | 10f. Zip Code<br><b>21214</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>                             |  |   |                                       |  |                                   |    |    |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced  |                                       | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: <b>1959-1962</b> |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>White</b> |  |   |                                       |  |                                   |    |    |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)  |                                       | 15b. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Laborer</b>  |  | 16b. Kind of Business/Industry<br><b>Construction</b>  |  |   |  |   |                                       |  |                                   |    |    |
|   | 17. Father's Name (First, Middle, Last)<br><b>Walter Karrasch</b>   |                                       |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Frieda Foerster</b>  |  |   |  |   |                                       |  |                                   |    |    |
|   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Selina Rupp/Daughter</b>   |                                       |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1054 Iris Ave. Baltimore, MD 21205</b>   |  |   |  |   |                                       |  |                                   |    |    |
|   | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |                                       | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Metro Crematory, Inc.</b>   |  | Date<br><b>8/6/97</b>  |  | 20c. Location - City or Town, State<br><b>Baltimore, MD</b>             |  |   |                                       |  |                                   |    |    |
|   | 21. Signature of Funeral Service Licensee<br><b>Edward A. Gregorchik</b>  |                                       |  |  | 22. Name and Address of Facility<br><b>Cremation Society of MD, Inc.<br/>299 Frederick Road Baltimore, MD 21228</b>  |  |   |  |   |                                       |  |                                   |    |    |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
|   | <table border="1"> <tr> <td rowspan="4">           Immediate Cause (Final disease or condition resulting in death)<br/><br/>           Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last         </td> <td>a. <b>Acute Myocardial Infarction</b></td> <td rowspan="4">Approximate Interval Between Onset and Death</td> </tr> <tr> <td>b. <b>Coronary Artery Disease</b></td> </tr> <tr> <td>c.</td> </tr> <tr> <td>d.</td> </tr> </table> |                                       |  |  |  |  |   |  | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last | a. <b>Acute Myocardial Infarction</b> | Approximate Interval Between Onset and Death | b. <b>Coronary Artery Disease</b> | c. | d. |
|   | Immediate Cause (Final disease or condition resulting in death)<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last   | a. <b>Acute Myocardial Infarction</b> | Approximate Interval Between Onset and Death   |  |  |  |   |  |   |                                       |  |                                   |    |    |
| b. <b>Coronary Artery Disease</b>   |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| c.  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| d.  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Congestive Heart Failure</b><br><b>Chronic Lung Disease</b><br><b>Peripheral Vascular Disease</b>  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 23b. Did tobacco use contribute to the cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No   |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined   |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 28a. Date of injury (Month, Day Year)<br>28b. Time of Injury<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 28d. Describe how injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State)   |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> <b>Certifying Physician:</b> To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> <b>Medical Examiner:</b> On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 29b. Signature and title of certifier<br><b>John A. Marra MD</b>  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 29c. License number<br><b>025075</b>  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 29d. Date signed (Month, Day, Year)<br><b>8/5/97</b>  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>JOHN FRANK MARRA MD</b>  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 31. Date filed (Month, Day, Year)<br><b>8/5/97</b>  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |
| 32. Registrar's Signature<br><b>Julia Davidson-Rendell</b>  |   |                                       |  |  |  |  |   |  |   |                                       |  |                                   |    |    |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

2





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State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23985

|  |  |   |   |                               |  |   |  |                                   |  |  |  |
|--|--|---|---|-------------------------------|--|---|--|-----------------------------------|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br>Peter Paul Kasper  |   |   |                               |  |   | 2. Date of Death<br>Month Day Year<br>August 6, 1997   |                                   | 3. Time of Death<br>2:37 a.m.                          |  |  |
|  | 4e. Facility Name (If not Institution, give street and number)<br>6109 Ridgeview Ave.  |   |   |                               |  |   | 4b. City, Town, or Location of Death<br>Baltimore  |                                   | 4c. County of Death<br>N/a                             |  |  |
| Funeral<br>Director  | 5. Social Security Number<br>148-26-1744   |   | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |                               | 7. Age (In yrs. last birthday)<br>64 Yrs.  |   | 8. Date of Birth (Month, Day, Year)<br>January 14, 1933  |                                   | 9. Birthplace (State or Foreign Country)<br>New Jersey |  |  |
|  | Usual Residence of Decedent  |   |   |                               |  |   | 10e. State<br>Maryland   |                                   | 10b. County<br>N/A                                     |  | 10c. City, Town or Location<br>Baltimore |
| To Be Completed by Funeral Director  | 10e. State   |   | 10b. County   |                               | 10c. City, Town or Location  |   | 10d. Inside City Limits<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |                                   |  |  |  |
|  | 10e. Street and Number<br>6109 Ridgeview Ave.  |   | 10f. Zip Code<br>21206  |                               | 10g. Citizen of What Country?<br>U.S.A.  |   |  |                                   |  |  |  |
|  | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |   | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: 12/10/53-09/20/55 |                               | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: White   |                                   |  |  |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12)<br>3  |   | 16. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Data Processor  |                               | 16b. Kind of Business/Industry<br>State of Maryland  |   |  |                                   |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br>Basil unknown Kasper  |   |   |                               |  |   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Anna unknown Vasilcin   |                                   |  |  |  |
|  | 19e. Informant's Name/Relationship (Type, Print)<br>Marilyn M. Kasper/ Wife  |   |   |                               |  |   | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>6109 Ridgeview Ave., Baltimore, MD 21206  |                                   |  |  |  |
|  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)  |   | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Parkwood Cemetery   |                               | Date<br>8/12/1997  |   | 20c. Location - City or Town, State<br>Baltimore, MD   |                                   |  |  |  |
|  | 21. Signature of Funeral Service Licensee<br>  |   | 22. Name and Address of Facility<br>John C. Miller, Inc.<br>6415 Belair Road Balto., MD 21206   |                               |  |   |  |                                   |  |  |  |
|  | 23e. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br>a. SUDDEN CARDIAC DEATH<br>Due to (or as a consequence of):<br>b. IDIOPATHIC SYSTOLIC CARDIOMYOPATHY<br>Due to (or as a consequence of):<br>c.<br>Due to (or as a consequence of):<br>d. |   |   |                               |  |   | Approximate Interval Between Onset and Death<br>IMMEDIATE<br>TEN YEARS   |                                   |  |  |  |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br>CONGESTIVE HEART FAILURE<br>INSULIN DEPENDENT DIABETES MELLITUS  |   |   |                               |  |   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown |                                   |  |  |  |
| 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |   |   |                               |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) |  |                                   |  |  |  |
| 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation<br>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined<br>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide  |  | 28a. Date of Injury (Month, Day, Year)    |   | 28b. Time of Injury<br>M      |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how injury occurred |  |  |  |
| 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br> |   | 29c. License number<br>334041 |  | 29d. Date signed (Month, Day, Year)<br>AUGUST 6th, 1997   |  |                                   |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Dr. Fonda Good Samaritan Hospital 5601 Loch Raven Blvd. Balto. MD 21239  |  |   |   |                               |  |   |  |                                   |  |  |  |
| 31. Date filed (Month, Day, Year)<br>AUG 8 1997  |  |   |   |                               |  | 32. Registrar's Signature<br>   |  |                                   |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



AM

MICHAEL

KNILL

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

97 23986

Items: 23a part I, 27, 28a-f per MEO G-750 8/8/97

|                                     |   |  |   |  |   |  |   |  |  |  |
|-------------------------------------|---|--|---|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br>MICHAEL PAUL KNILL  |  |   |  | 2. Date of Death<br>Month Day Year<br>AUGUST 03, 1997   |  |   |  | 3. Time of Death<br>12:03 P  |  |
|                                     | 4a. Facility Name (If not Institution, give street and number)<br>4200 BLK. EASTERN AVE.  |  |   |  | 4b. City, Town, or Location of Death<br>BALTIMORE   |  |   |  | 4c. County of Death<br>N/A   |  |
| Funeral<br>Director                 | 5. Social Security Number<br>218-60-6515  |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>44 Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br>10/12/1952   |  | 9. Birthplace (State or Foreign Country)<br>MD   |  |
|                                     | Usual Residence of Decedent   |  |   |  |   |  |   |  |  |  |
| To Be Completed by Funeral Director | 10a. State<br>MD  |  | 10b. County<br>BALTIMORE  |  | 10c. City, Town or Location<br>DUNDALK  |  |   |  | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  |
|                                     | 10e. Street and Number<br>6701 GARY AVE.  |  |   |  | 10f. Zip Code<br>21222  |  | 10g. Citizen of What Country?<br>U.S.A.   |  |  |  |
|                                     | 11. Marital Status<br>1 <input checked="" type="checkbox"/> Navar Married 2 <input type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE |  |  |
|                                     | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>12  |  |   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>DISPATCHER   |  |   | 16b. Kind of Business/Industry<br>TRUCKING                       |  |  |
|                                     | 17. Father's Name (First, Middle, Last)<br>RUSSELL T. KNILL, SR.  |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br>GLADYS A. EISENHOWER   |  |   |  |  |  |
|                                     | 19a. Informant's Name/Relationship (Type, Print)<br>RUSSELL KNILL/ BROTHER  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>224 BOWLEYS QUARTER RD., BALTIMORE, MD 21220   |  |   |  |  |  |
|                                     | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>GARDENS OF FAITH CEM.   |  | 20c. Location - City or Town, State<br>BALTIMORE, MD  |  |   |  |  |  |
|                                     | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br>BRADLEY-ASHTON FUNERAL HOME, INC.<br>2134 WILLOW SPRING RD. DUNDALK, MD 21222   |  |   |  |  |  |
|                                     | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. NARCOTIC INTOXICATION<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last |  |   |  |   |  |   |  |  |  |
|                                     | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |   |  |   |  |   |  |  |  |
| Physician<br>/Medical<br>Examiner   | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown   |  |   |  | 24a. Was an autopsy performed?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  |  |  |
|                                     |   |  |   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |   |  |  |  |
|                                     | 25. Was case referred to medical examiner?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No   |  |   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) R/R TRACK |  |   |  |  |  |
|                                     | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input checked="" type="checkbox"/> Could not be determined  |  | 28a. Date of Injury (Month, Day, Year)<br>found 8/3/97  |  | 28b. Time of Injury<br>unknown M  |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No |  | 28d. Describe how injury occurred<br>unknown   |  |
|                                     | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>found in woods  |  |   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)<br>4200 blk. Eastern Ave., Baltimore, Md.  |  |   |  |  |  |
|                                     | 29a. Certifier (Check one)<br>1 <input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.  |  |   |  |   |  |   |  |  |  |
|                                     | 29b. Signature and title of certifier<br>  |  |   |  | 29c. License number<br>OCME   |  | 29d. Date signed (Month, Day, Year)<br>AUGUST 04, 1997  |  |  |  |
|                                     | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>J. L. L. L. L. 111 Penn Street, Baltimore, Maryland 21201   |  |   |  |   |  |   |  |  |  |
|                                     | 31. Date filed (Month, Day, Year)<br>AUG 08 1997  |  |   |  | 32. Registrar's Signature<br>  |  |   |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23987

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

John Francis LANGER

2. Date of Death

August 6, 1997

3. Time of Death

0600 AM

4a. Facility Name (If not institution, give street and number)

Gilcrest Hospice Center

4b. City, Town, or Location of Death

Towson

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

370-34-8319

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

60 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

Aug. 22, 1936

9. Birthplace (State or Foreign Country)

Michigan

Usual Residence of Decedent

10a. State

Maryland Baltimore

10b. County

10c. City, Town or Location

Timonium

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

16 Daria Ct.

10f. Zip Code

21093

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 yrs

College (1-4 or 5+)

2 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Salesman

16b. Kind of Business/Industry

Northwestern Heating &amp; Air

17. Father's Name (First, Middle, Last)

Carl Langer

18. Mother's Name (First, Middle, Maiden Surname)

Vada Oglesby

19a. Informant's Name/Relationship (Type, Print)

Gayle Langer

wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

16 Daria Ct. Timonium, Maryland 21093

20a. Method of Disposition

1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel-Bel Air

Date

Aug 7

20c. Location - City or Town, State

Forest Hill, Maryland

21. Signature of Funeral Service Licensee

Krista S. Wells

22. Name and Address of Facility

Evans Chapel of Chimes  
2325 York Rd. Timonium, Md 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. metastatic Lung Cancer

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Approximate Interval Between Onset and Death

6 month

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Laryngeal cancer

23b. Did tobacco use contribute to the cause of death?

1 ☒ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 5 ☐ Pending Investigation  
2 ☐ Accident 6 ☐ Could not be determined  
3 ☐ Suicide 4 ☐ Homicide

28a. Date of Injury (Month, Day Year)

None

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

Anthony Riley

29c. License number

D25205

29d. Date signed (Month, Day, Year)

August 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

W. A. Riley GBRAC 6701 N. Charles St. Balto, md 21204

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

J. K. R. R. R.

State  
Registrar

Baltimore, Maryland 21215-0020

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23988

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Raymond Dulin Lowry, Jr.

2. Date of Death

Month Day Year  
AUGUST 3 1997

3. Time of Death

5:45 pm

4a. Facility Name (If not institution, give street and number)

GREATER BALTIMORE MEDICAL CENTER

4b. City, Town, or Location of Death

TOWSON

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

220-12-9068

6. Sex

1 ☒ M 2 ☐ F

7. Age (In yrs. last birthday)

76

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

(Month, Day, Year)  
June 2, 1921

9. Birthplace (State or Foreign Country)

MD

Usual Residence of Decedent

10e. State

MD

10b. County

Baltimore

10c. City, Town or Location

Baldwin

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

4911 Horse Hill Road

10f. Zip Code

21013

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married 2 ☒ Married  
3 ☐ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
12

College (1-4 or 5+)

16a. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Printer

16b. Kind of Business/Industry

Printing Industry

17. Father's Name (First, Middle, Last)

Raymond Dulin Lowry, Sr.

18. Mother's Name (First, Middle, Maiden Surname)

Gertrude I. Ermer

19a. Informant's Name/Relationship (Type, Print)

Edith M. Lowry - Wife

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4911 Horse Hill Road, Baldwin, MD 21013

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Dulaney Valley Mem. Gardens

Date

Aug. 7, 1997

20c. Location - City or Town, State

Timonium, MD 21093

21. Signature of Funeral Service Licensee



22. Name and Address of Facility

Lemmon Funeral Home, Inc.

10 W. Padonia Rd., Timonium, MD 21093

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final  
disease or condition  
resulting in death)a. INTRACEREBRAL HEMORRHAGE

Due to (or as a consequence of):

3

Sequentially list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Lastb. CEREBRAL VASCULAR ACCIDENT

Due to (or as a consequence of):

3

c. \_\_\_\_\_  
Due to (or as a consequence of):d. \_\_\_\_\_  
Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☐ No25. Was case referred to medical  
examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

28. Place of Death (Check only one)

Other: 4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

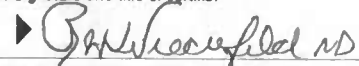
27. Manner of Death

1 ☒ Natural 5 ☐ Pending  
investigation  
2 ☐ Accident 6 ☐ Could not be  
determined  
3 ☐ Suicide 4 ☐ Homicide28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury28c. Injury at  
Work?  
1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier



29c. License number

D33011

29d. Date signed (Month, Day, Year)

8/4/97

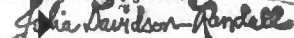
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

R. WIGDEGGER 3346 PAPERNAKE Rd PHOENIX MD 21131

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 202-354-0028.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Raymond Lowry

9

15





B.K.S

ANTHONY MARTIN

Items: 23a part 1, 27 per MEO G-751 9/24/97 dh  
ITEM: 8 per FH G-750 8-8-97 eoh

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23989

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Anthony D. Martin

2. Date of Death

Month Day Year  
AUG. 05, 1997

3. Time of Death

12:10PM

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

JOHNS HOPKINS BAYVIEW MEDICAL CENTER E.R.

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

5. Social Security Number

218-84-3739

6. Sex

M ☒ F ☐

7. Age (In yrs. last birthday)

32 Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

August 5, 1965

9. Birthplace (State or Foreign Country)

Ohio

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

☒ Yes ☐ No

10e. Street and Number

5404 Daywalt Street

10f. Zip Code

21206

10g. Citizen of What Country?

U.S.A.

11. Marital Status

☒ Never Married ☐ Married☐ Widowed ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

☐ Yes ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

☐ Yes ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12 Years

College (1-4 or 5+)

N/A

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Disabled

16b. Kind of Business/Industry

N/A

17. Father's Name (First, Middle, Last)

Gerald Alden Martin

18. Mother's Name (First, Middle, Maiden Surname)

Ilena Gale Frey

19a. Informant's Name/Relationship (Type, Print)

Mrs. Victoria Lee Blackburn

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

P.O. Box 283 Union Bridge, MD 21791

20a. Method of Disposition

☒ Burial ☐ Cremation ☐ Removal from State☐ Donation ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Linthicum Chapel Cemetery

Date

8/9/97

20c. Location - City or Town, State

Clarksville, MD

21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Loring Byers Funeral Directors, Inc.

8728 Liberty Road Randallstown, MD

21133

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. COMPLICATIONS OF DANDY-WALKER SYNDROME

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

☐ Yes ☒ No ☐ Probably ☐ Unknown

24a. Was an autopsy performed?

☒ Yes ☐ No

24b. Were autopsy findings available prior to completion of cause of death?

☒ Yes ☐ No

25. Was case referred to medical examiner?

☒ Yes ☐ No

Hospital:

☐ Inpatient ☒ Outpatient ☐ DOA

Other:

26. Place of Death (Check only one)

☐ Nursing Home ☐ Residence ☐ Other (Specify)

27. Manner of Death

☒ Natural☐ Accident☐ Suicide☐ Homicide☐ Pending Investigation☐ Could not be determined

28a. Date of Injury (Month, Day Year)

28b. Time of Injury

28c. Injury at Work?

☐ Yes ☒ No

28d. Describe how Injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

☐ Certifying Physician☒ Medical Examiner

To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

29c. License number

O.C.M.E

29d. Date signed (Month, Day, Year)

AUG. 6, 1997

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R Fowler

111 Penn Street, Baltimore, Maryland 21201

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

[Signature]

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To Be Completed by Funeral Director

To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

T

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23990

Items: 23a part I, II, 27 per MEO G-750 8/20/97 dh  
DENEEN MARIE MINOR

## Certificate of Death

Reg. No.

|  |  |  |   |  |   |  |  |  |
|--|--|--|---|--|---|--|--|--|
| Physician<br>/Medical<br>Examiner  | 1. Decedent's Name (First, Middle, Last)<br><b>DENEEN MARIE MINOR</b>  |  |   |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 03 1997</b>   |  | 3. Time of Death<br><b>12:32 PM</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>1562 WOODYEAR STREET</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>  |  | 4c. County of Death<br><b>N/A</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>215-76-9238</b>  |  | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>33</b> Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br><b>JUNE 10, 1964</b>  |  |
|  | 9. Birthplace (State or Foreign Country)<br><b>MARYLAND</b>  |  | 10a. State<br><b>MARYLAND</b>   |  | 10b. County<br><b>N/A</b>   |  | 10c. City, Town or Location<br><b>BALTIMORE CITY</b>   |  |
| To Be Completed by Funeral Director  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 10e. Street and Number<br><b>1562 N. WOODYEAR STREET</b>  |  | 10f. Zip Code<br><b>21217</b>   |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:   |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>  |  |
| To Be Completed by Physician/Medical Examiner                                | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>DATA DEVICE OPERATOR</b>  |  | 16b. Kind of Business/Industry<br><b>MD. STATE DEPT.</b>  |  |  |  |
|  | 17. Father's Name (First, Middle, Last)<br><b>CHARLES RUFFIN</b>   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>JOYCE DABNEY</b>  |  | 19. Informant's Name/Relationship (Type, Print)<br><b>PAUL MINOR (HUSBAND)</b>  |  |  |  |
| Physician<br>/Medical<br>Examiner  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>KING MEMORIAL PARK</b>   |  | 20c. Location - City or Town, State<br><b>8-8-97 WOODLAWN, MD</b>   |  | 21. Signature of Funeral Service Licensee<br><b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A.</b>   |  |
|  | 22. Name and Address of Facility<br><b>2140 N. FULTON AVE. BALTIMORE, MD. 21217</b>  |  | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><b>HYPERTROPHIC CARDIOMYOPATHY</b> |  | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |  | 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No  |  |
| Division of Vital Records, P.O. Box 68760,<br>Baltimore, Maryland 21215-0020 | 24b. Were autopsy findings available prior to completion of cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined |  |
|  | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>   |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 28d. Describe how injury occurred  |  |
| State<br>Registrar   | 29a. Certifier (Check only one)<br><input type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br><b>J. LARON WATKINS, MD</b>  |  | 29c. License number<br><b>O.C.M.E.</b>  |  | 29d. Date signed (Month, Day, Year)<br><b>AUGUST 04, 1997</b>  |  |
|  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>J. LARON WATKINS, MD 111 Penn Street, Baltimore, Maryland 21201</b>   |  | 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |  | 32. Registrar's Signature<br><b>Julia Davidson-Rendell</b>  |  |  |  |

KING MEMORIAL PARK 8-8-67 WOODBURY, MD.

*[Handwritten signature]*

X


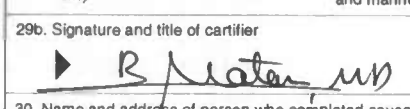
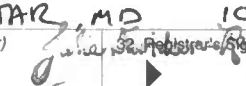
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23991

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>Robert L. McMillan</b>  |  |   |  | 2. Date of Death<br>Month <b>August</b> Day <b>04</b> Year <b>97</b>   |  | 3. Time of Death<br><b>5:30pm</b>  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>811 Belnord Avenue</b>  |  |   |  | 4b. City, Town, or Location of Death<br><b>Baltimore</b>   |  | 4c. County of Death<br><b>NA</b>   |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>217-24-8263</b>  |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.   | 8. Date of Birth (Month, Day, Year)<br><b>05-07-30</b>   | 9. Birthplace (State or Foreign Country)<br><b>Md.</b>   |
|   | Usual Residence of Decedent  |  |   |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>Md.</b>   |  | 10b. County<br><b>NA</b>  |  | 10c. City, Town or Location<br><b>Baltimore</b>  |  | 10d. Inside City Limits<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No |  |
|   | 10e. Street and Number<br><b>811 Belnord Avenue</b>  |  |   |  | 10f. Zip Code<br><b>21205</b>  |  | 10g. Citizen of What Country?<br><b>USA</b>  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>Black</b>                        |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>10th Grade</b><br>College (1-4 or 5+) <b>NA</b>  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Construction worker</b>           |  | 16b. Kind of Business/Industry<br><b>Construction Co.</b>  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>Alexander McMillan</b>   |  |   |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>Melinda Rodey</b>  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>Delores McMillan</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21205 811 Belnord Avenue Baltimore, Maryland</b>  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>Garrison Forest VA Cem. 08-11-97 Owings Mills,</b>                   |  | Date<br><b>Md.</b>   |  | 20c. Location - City or Town, State  |  |
|   | 21. Signature of Funeral Service Licensee<br>  |  | 22. Name and Address of Facility<br><b>Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue</b>   |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic lung Cancer</b>                         |  |   |  |  |  |  |  |
|   | Due to (or as a consequence of):<br><br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |  |   |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |  |  |   |  |  | 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |  |  |
|   |  |  |   |  |  | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |  | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |   |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined<br><input type="checkbox"/> Suicide <input type="checkbox"/> Homicide |  | 28a. Date of Injury (Month, Day Year)  |   | 28b. Time of Injury<br><b>M</b>                  |  | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |  | 28d. Describe how Injury occurred  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Medical Examiner   |  | 29b. Signature and title of certifier<br><br><b>BASSAM MATAR MD</b>   |   |  |  |  |  | 29c. License number<br><b>D45102</b>   |
| 29d. Data signed (Month, Day, Year)<br><b>8.6.97</b>  |  | 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)<br><b>10 N. Greene St. VA Medical Center Baltimore, MD 21201</b>  |   |  |  |  |  |  |
| 31. Date Filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |  | 32. Registrar's Signature<br>   |   |  |  |  |  |  |

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the physician, Attending Physician: The law requires that the death certificate be executed within 72 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23992

|  |   |                          |  |  |  |   |   |  |
|--|---|--------------------------|--|--|--|---|---|--|
| Physician<br>/Medical<br>Examiner                                    | 1. Decedent's Name (First, Middle, Last)<br><b>ANNIE MACK</b>   |                          |  |  | 2. Date of Death<br>Month <b>AUG.</b> Day <b>07</b> Year <b>1997</b>   |   | 3. Time of Death<br><b>4:00 P.M.</b>  |  |
|  | 4a. Facility Name (If not institution, give street and number)<br><b>STELLA MARIS-MERLY HOSPITAL</b>  |                          |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE</b>   |   | 4c. County of Death<br><b>NA</b>  |  |
| Funeral<br>Director  | 5. Social Security Number<br><b>214-14-5671</b>   |                          | 6. Sex<br><input type="checkbox"/> M <input checked="" type="checkbox"/> F   | 7. Age (In yrs. last birthday)<br><b>80</b> Yrs. | If Under 1 Year<br>Months Days   | If Under 24 Hrs.<br>Hours Min.  | 8. Date of Birth (Month, Day, Year)<br><b>12/4/16</b>                                       | 9. Birthplace (State or Foreign Country)<br><b>NC</b>  |
|  | Usual Residence of Decedent   |                          |  |  |  |   |   |  |
| To Be Completed by Funeral Director                                  | 10a. State<br><b>MD</b>   | 10b. County<br><b>NA</b> | 10c. City, Town or Location<br><b>BALTIMORE</b>  |  |  | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input type="checkbox"/> No |   |  |
|  | 10e. Street and Number<br><b>5423 GIST AVE</b>  |                          |  | 10f. Zip Code<br><b>21215</b>                    |  | 10g. Citizen of What Country?<br><b>USA</b>   |   |  |
|  | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |                          | 12. Was Decedent Ever in U.S. Armed Forces?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>BLACK</b>                     |  |
|  | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>NA</b>  |                          | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>Clerk</b>  |  | 16b. Kind of Business/Industry<br><b>FEDERAL GOVERNMENT</b>  |   |   |  |
| To Be Completed by Physician/Medical Examiner                        | 17. Father's Name (First, Middle, Last)<br><b>ALBERT WITHERS</b>  |                          |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ANNIE ALEXANDER</b>  |   |   |  |
|  | 19a. Informant's Name/Relationship (Type, Print)<br><b>FLORANCE A. MACK - Daughter</b>  |                          |  |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>4113 BUCKINGHAM RD. BALTO. MD, 21207</b>   |   |   |  |
|  | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)   |                          | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>WOODLAWN CEMETARY</b>   |  | Date<br><b>8/11/97</b>   |   | 20c. Location - City or Town, State<br><b>BALTIMORE MD</b>                                  |  |
|  | 21. Signature of Funeral Service Licensee<br>   |                          | 22. Name and Address of Facility<br><b>ALBERT P. WYLLIE F.H. PA<br/>638 N. GILMER STREET BALTO. MD 21217</b>   |  |  |   |   |  |
| Physician<br>/Medical<br>Examiner                                    | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br><br>Immediate Cause (Final disease or condition resulting in death)<br><b>a. Metastatic Breast Cancer</b><br>Due to (or as a consequence of):<br><br>Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last<br><b>b. Due to (or as a consequence of):</b><br><b>c. Due to (or as a consequence of):</b><br><b>d. Due to (or as a consequence of):</b> |                          |  |  |  |   |   | Approximate Interval Between Onset and Death<br><b>UNKNOWN</b>   |
|  | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |                          |  |  |  |   |   | 23b. Did tobacco use contribute to the cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown |
|  |   |                          |  |  |  |   |   | 24a. Was an autopsy performed?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |
|  |   |                          |  |  |  |   |   | 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |
| Medical Certification: To Be Completed by Physician/Medical Examiner | 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |                          | 26. Place of Death (Check only one)<br>Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HOSPICE</b> |  |  |   |   |  |
|  | 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |                          | 28a. Date of Injury (Month, Day, Year)   |  | 28b. Time of Injury<br><b>M</b>  |   | 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |  |
|  |   |                          | 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  |  |   | 28d. Describe how injury occurred   |  |
|  |   |                          | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  |  |   |   |  |
| State Registrar  | 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.   |                          |  |  |  |   |   |  |
|  | 29b. Signature and title of certifier<br>   |                          |  |  | 29c. License number<br><b>D40480</b>   |   | 29d. Date signed (Month, Day, Year)<br><b>August 7, 1997</b>                                |  |
|  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>FERNANDO V. TERRO MD</b>   |                          |  |  | <b>5810 BELAIR RD<br/>BALTO., MD 21206</b>   |   |   |  |
|  | 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |                          | 32. Registrar's Signature<br>  |  |  |   |   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

*[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side. The text is too light to transcribe accurately.]*



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State of Maryland / Department of Health and Mental Hygiene

97 23993

## Certificate of Death

Reg. No.

|   |   |  |  |  |  |  |   |  |
|---|---|--|--|--|--|--|---|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>Elizabeth Rae Mizopalko   |  |  |  | 2. Date of Death<br>Month Day Year<br>August 1, 1997   |  | 3. Time of Death<br>10:15 AM  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>5335 Onion Road   |  |  |  | 4b. City, Town, or Location of Death<br>Pylesville   |  | 4c. County of Death<br>Harford  |  |
| Funeral<br>Director                           | 5. Social Security Number<br>183-44-8729  |  | 6. Sex<br>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F   |  | 7. Age (In yrs. last birthday)<br>38 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>January 28, 1959   |  |
|   | 9. Birthplace (State or Foreign Country)<br>Pennsylvania  |  | 10a. State<br>Maryland   |  | 10b. County<br>Harford   |  | 10c. City, Town or Location<br>Pylesville   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 10e. Street and Number<br>5335 Onion Road  |  | 10f. Zip Code<br>21132   |  | 10g. Citizen of What Country?<br>USA  |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever In U.S. Armed Forces?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No<br>If Yes, Give Year or Dates:  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify: |  | 14. Race - American Indian, Black, White, etc.<br>Specify: White  |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) 1 College (1-4or 5+)   |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>Administrative Secretary  |  | 16b. Kind of Business/Industry<br>Social Work  |  | 17. Father's Name (First, Middle, Last)<br>Wendell Hostler  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>Elizabeth Scott  |  | 19a. Informant's Name/Relationship (Type, Print)<br>Gregory W. Mizopalko   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>5335 Onion Road, Pylesville, Md. 21132  |  | 20a. Method of Disposition<br>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)   |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>Centre Presbyterian Cem.  |  | 20c. Date<br>8/4/97  |  | 20d. Location - City or Town, State<br>Fawn Grove, Pa.   |  | 21. Signature of Funeral Service Licensee<br>   |  |
|   | 22. Name and Address of Facility<br>J.J. Hartenstein Mortuary, Inc.<br>19 S. Main St., Stewartstown, Pa. 17363  |  | 23a. Pertinent disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line.<br>Cancer of Cervix |  | Approximate Interval Between Onset and Death<br>2 years  |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input type="checkbox"/> Unknown  |  |
| To Be Completed by Physician/Medical Examiner | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)   |  |
|   | 27. Manner of Death<br>1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined |  | 28a. Date of injury (Month, Day, Year)   |  | 28b. Time of Injury<br>M   |  | 28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 28d. Describe how injury occurred   |  | 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)   |  | 28f. Location (Street and Number or Rural Route Number, City or Town, State)   |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. |  |
|   | 29b. Signature and title of certifier<br>Seamus O'Reilly MD PhD   |  | 29c. License number<br>D46515  |  | 29d. Date signed (Month, Day, Year)<br>August 3 <sup>rd</sup> 1997   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>Seamus O'Reilly Johns Hopkins Oncology Center, Baltimore MD 21287   |  |
| State Registrar                               | 31. Date filed (Month, Day, Year)<br>AUG 08 1997  |  | 32. Registrar's Signature<br>Julia F. Davidson-Randall   |  | 33. Date of Death (Month, Day, Year)<br>August 1, 1997   |  | 34. Time of Death<br>10:15 AM   |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



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State of Maryland / Department of Health and Mental Hygiene

97 23994

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Elsie A. Myers

2. Date of Death

August 7, 1997

3. Time of Death

12:57 PM

4a. Facility Name (If not Institution, give street and number)

Charlestown Care Center

4b. City, Town, or Location of Death

Catonsville

4c. County of Death

Baltimore

Funeral  
Director

5. Social Security Number

213-20-7048

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

75

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

December 29, 1921

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

Washington

10c. City, Town or Location

Boonsboro

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

109 Della Lane

10f. Zip Code

21713

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever In U.S.

Armed Forces?  
1 ☐ Yes 2 ☒ No  
If Yes, Give  
Year or Dates:13. Was Decedent of Hispanic Origin? (Specify Yes or No-  
If Yes, specify Cuban, Mexican, Puerto Rican, etc.)1 ☐ Yes 2 ☒ No Specify:14. Race - American Indian,  
Black, White, etc.

Specify: White

15. Decedent's Education  
(Specify only highest grade completed)Elementary/Secondary (0-12)  
10

College (1-4or 5+)

16. Decedent's Usual Occupation  
(Give kind of work done during most of working  
life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Edward B. Grimes

18. Mother's Name (First, Middle, Maiden Surname)

Helen M. Anderson

19a. Informant's Name/Relationship (Type, Print)

Donald E. Kemp, Sr. / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

11 Locust Drive Catonsville, MD 21228

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)20b. Place of Disposition (Name of  
cemetery, crematory or other place)

Boonsboro Cemetery

Date

8/9/97

20c. Location - City or Town, State

Boonsboro, Maryland

21. Signature of Funeral Service Licensee

Timothy S. Harman

22. Name and Address of Facility

Leonard J. Ruck, Inc. Funeral Home  
5305 Harford Road Baltimore, MD 2121423a. Pert. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  
shock, or heart failure. List only one cause on each line.Immediate Cause (Final  
disease or condition  
resulting in death)

e. congestive cardiomyopathy

Due to (or as a consequence of):

Approximate  
Interval Between  
Onset and Death

Years

Sequently list conditions,  
if any, leading to immediate  
cause. Enter Underlying  
Cause (Disease or injury  
that initiated events  
resulting in death) Last

b. atherosclerotic coronary artery disease

Due to (or as a consequence of):

c. Due to (or as a consequence of):

d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown24a. Was an autopsy  
performed?1 ☐ Yes 2 ☒ No24b. Were autopsy findings  
available prior to  
completion of cause  
of death?1 ☐ Yes 2 ☒ No25. Was case referred to medical  
examiner?1 ☐ Yes 2 ☒ No

26. Place of Death (Check only one)

Hospital:

1 ☐ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☒ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural  
2 ☐ Accident  
3 ☐ Suicide  
4 ☐ Homicide5 ☐ Pending  
Investigation  
6 ☐ Could not be  
determined28a. Date of Injury  
(Month, Day Year)28b. Time of  
Injury

M

28c. Injury at  
Work?1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office  
building, etc. (Specify)28f. Location (Street and Number or Rural Route Number,  
City or Town, State)29a. Certifier  
(Check only  
one)1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  
2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)  
and manner stated.

29b. Signature and title of certifier

Myla M. Carpenter

29c. License number

D 30989

29d. Date signed (Month, Day, Year)

08/07/97

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

Myla M. Carpenter MD 711 Maiden Choice Ln Catonsville

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

June Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland  
Department of Health and Mental Hygiene.  
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show  
any injury or other traumatic event, the Medical Examiner must be notified at  
once.Physician  
/Medical  
Examiner

Medical Certification: To Be Completed by Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed  
within 24 hours after death.  
To the Funeral Director: After this certificate has been signed by the attending physician and  
completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Name:

Division of Vital Records, P.O. Box 68760,

5



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State of Maryland / Department of Health and Mental Hygiene

97 23995

## Certificate of Death

Reg. No.

|   |  |  |   |  |  |  |  |  |
|---|--|--|---|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner             | 1. Decedent's Name (First, Middle, Last)<br>WILBUR JOSEPH MOYER  |  |   |  | 2. Date of Death<br>Month Day Year<br>AUGUST 4, 1997   |  | 3. Time of Death<br>9:30PM   |  |
|   | 4a. Facility Name (If not institution, give street and number)<br>Charlestown Care Center  |  |   |  | 4b. City, Town, or Location of Death<br>Catonsville  |  | 4c. County of Death<br>Baltimore   |  |
| Funeral<br>Director                           | 5. Social Security Number<br>172-18-1319   |  | 6. Sex<br>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br>83 Yrs.  |  | 8. Date of Birth (Month, Day, Year)<br>JUL 26 1914   |  |
|   | 9. Birthplace (State or Foreign Country)<br>PA   |  | 10a. State<br>MD  |  | 10b. County<br>BALTIMORE   |  | 10c. City, Town or Location<br>CATONSVILLE   |  |
| To Be Completed by Funeral Director           | 10d. Inside City Limits<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 10e. Street and Number<br>719 MAIDEN CHOICE LN., HR412  |  | 10f. Zip Code<br>21228   |  | 10g. Citizen of What Country?<br>USA   |  |
|   | 11. Marital Status<br>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married<br>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced   |  | 12. Was Decedent Ever in U.S. Armed Forces?<br>1 <input checked="" type="checkbox"/> Yes 2 <input type="checkbox"/> No 1946<br>If Yes, Give Year or Date: 1943  |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No - If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No Specify:  |  | 14. Race - American Indian, Black, White, etc.<br>Specify: WHITE   |  |
| To Be Completed by Physician/Medical Examiner | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) Collage (1-4 or 5+)<br>4  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br>METEOROLOGIST  |  | 16b. Kind of Business/Industry<br>NATIONAL WEATHER SERVICE   |  | 17. Father's Name (First, Middle, Last)<br>RICHARD C. MOYER  |  |
|   | 18. Mother's Name (First, Middle, Maiden Surname)<br>MARY A. DOUGHERTY   |  | 19a. Informant's Name/Relationship (Type, Print)<br>LOUISE M. MOYER, WIFE   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br>719 MAIDEN CHOICE LN. HR412 CATONSVILLE, MD 21228   |  | 20a. Method of Disposition<br>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State<br>4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) ENTOMBMENT                             |  |
| To Be Completed by Physician/Medical Examiner | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br>RESURRECTION CEMETERY  |  | 20c. Location - City or Town, State<br>CLINTON, MD  |  | 21. Signature of Funeral Service Licensee<br>Phillip Stahl   |  | 22. Name and Address of Facility<br>STERLING ASHTON FUNERAL HOME, INC.<br>736 EDMONDSON AVE. CATONSVILLE, MD 21228   |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>Immediate Cause (Final disease or condition resulting in death)<br>a. Dementia<br>Due to (or as a consequence of):<br>b. Due to (or as a consequence of):<br>c. Due to (or as a consequence of):<br>d. Due to (or as a consequence of):<br>Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last |  | Approximate Interval Between Onset and Death<br>years   |  | 23b. Did tobacco use contribute to the cause of death?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Probably 4 <input checked="" type="checkbox"/> Unknown   |  | 24a. Was an autopsy performed?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No  |  |
| To Be Completed by Physician/Medical Examiner | 24b. Were autopsy findings available prior to completion of cause of death?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 25. Was case referred to medical examiner?<br>1 <input type="checkbox"/> Yes 2 <input checked="" type="checkbox"/> No   |  | 26. Place of Death (Check only one)<br>Hospital: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA Other: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)  |  | 27. Manner of Death<br>1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide<br>5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined |  |
|   | 28a. Date of Injury (Month, Day Year)<br>28b. Time of Injury<br>M<br>28c. Injury at Work?<br>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No  |  | 28d. Describe how Injury occurred<br>28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)<br>28f. Location (Street and Number or Rural Route Number, City or Town, State) |  | 29a. Certifier (Check only one)<br>1 <input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br>2 <input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. |  | 29b. Signature and title of certifier<br>John Davidson-Randall, MD   |  |
| To Be Completed by Physician/Medical Examiner | 29c. License number<br>047447  |  | 29d. Date signed (Month, Day, Year)<br>August 5, 1997   |  | 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br>John Davidson-Randall 711 Maiden Choice Lane Catonsville   |  | 31. Data filed (Month, Day, Year)<br>AUG 08 1997   |  |
|   | 32. Registrar's Signature<br>John Davidson-Randall   |  | 33. Registrar's Signature   |  | 34. Registrar's Signature  |  | 35. Registrar's Signature  |  |

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 23e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



97 23996

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|  |  |  |  |   |  |   |  |   |  |
|--|--|--|--|---|--|---|--|---|--|
| 1. DECEDENT'S NAME (First, Middle, Last)<br><b>Robert N. Martin</b>  |  |  |  | 2. DATE OF DEATH<br>MONTH <b>August</b> DAY <b>6</b> YEAR <b>1997</b>   |  |   |  | 3. TIME OF DEATH<br><b>1:00 A</b> M   |  |
| 4. SOCIAL SECURITY NUMBER<br><b>246-40-1413</b>  |  | 5. SEX<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F   |  | 6. AGE (In yrs. last birthday)<br><b>66</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS <b>0</b> DAYS <b>0</b>  |  | IF UNDER 24 HRS.<br>HOURS <b>0</b> MIN. <b>0</b>  |  |
| 7. DATE OF BIRTH<br>(Month, Day, Year)<br><b>July 6, 1931</b>  |  |  |  | 8. BIRTHPLACE (State or Foreign Country)<br><b>Raleigh, NC</b>  |  |   |  |   |  |
| 9a. FACILITY NAME (If not institution, give street and number)<br><b>1624 Rickenbacker Road-Apt. B</b>   |  |  |  | 9b. CITY, TOWN OR LOCATION OF DEATH<br><b>Essex</b>   |  |   |  | 9c. COUNTY OF DEATH<br><b>Baltimore County</b>  |  |
| 10a. STATE<br><b>Maryland</b>  |  | 10b. COUNTY<br><b>Baltimore County</b>   |  | 10c. CITY, TOWN OR LOCATION<br><b>Essex</b>   |  |   |  | 10d. INSIDE CITY LIMITS?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO       |  |
| 10e. STREET AND NUMBER<br><b>1624 Rickenbacker Road-Apt. B</b>   |  |  |  | 10f. ZIP CODE<br><b>21221</b>   |  | 10g. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 11. MARITAL STATUS<br><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married<br><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced   |  | 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO<br>IF YES, GIVE WAR OR DATES   |  | 13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—<br>If yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: |  |   |  | 14. RACE — American Indian, Black, White, etc.<br>Specify:<br><b>Black</b>                            |  |
| 15. DECEDENT'S EDUCATION<br>(Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b></b>  |  |  |  | 16a. DECEDENT'S USUAL OCCUPATION<br>(Give kind of work done during most of working life. Do NOT use retired.)<br><b>Limo Driver</b>   |  |   |  | 16b. KIND OF BUSINESS/INDUSTRY<br><b>Private</b>  |  |
| 17. FATHER'S NAME (First, Middle, Last)<br><b>York Morehead</b>  |  |  |  | 18. MOTHER'S NAME (First, Middle, Maiden Surname)<br><b>Annie Morehead</b>  |  |   |  |   |  |
| 19a. INFORMANT'S NAME (Type/Print)<br><b>Louise Martin</b>   |  |  |  | 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>1604 Rickenbacker Road-Apt. G, Essex, MD 21221</b>  |  |   |  |   |  |
| 20a. METHOD OF DISPOSITION<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)  |  | 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)<br><b>Garrison Forest Veterans 8/12/97</b>   |  |   |  | 20c. LOCATION — City or Town, State<br><b>Owings Mills, MD</b>                              |  |   |  |
| 21. SIGNATURE OF FUNERAL SERVICE LICENSEE<br><i>Hani P. Close</i>  |  |  |  | 22. NAME AND ADDRESS OF FACILITY<br><b>William C. Brown Community F. H.<br/>1206 W. North Avenue, Balt., MD 21217</b>   |  |   |  |   |  |
| 23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.<br>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>a. <b>Arteriosclerotic Cardio Renal Vascular Disease</b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>c. <b></b><br>DUE TO (OR AS A CONSEQUENCE OF):<br>d. <b></b><br>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST |  |  |  |   |  |   |  | Approximate Interval Between Onset and Death  |  |
| PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.<br><b>Ethanol Abuse</b>   |  |  |  |   |  |   |  | 24a. WAS AN AUTOPSY PERFORMED?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  |
| 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO   |  |  |  |   |  |   |  |   |  |
| DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>  |  |  |  |   |  |   |  |   |  |
| 25. WAS CASE REFERRED TO MEDICAL EXAMINER?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  |  | 26. PLACE OF DEATH (Check only one)<br>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA<br>OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) |  |   |  |   |  |   |  |
| 27. MANNER OF DEATH<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation<br><input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide<br><input type="checkbox"/> Could not be determined  |  | 28a. DATE OF INJURY<br>(Month, Day, Year)  |  | 28b. TIME OF INJURY<br><b>M</b>   |  | 28c. INJURY AT WORK?<br><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO |  | 28d. DESCRIBE HOW INJURY OCCURRED   |  |
| 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)   |  | 28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)   |  |   |  |   |  |   |  |
| 29a. CERTIFIER (Check only one)<br><input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.   |  |  |  |   |  |   |  |   |  |
| 29b. SIGNATURE AND TITLE OF CERTIFIER<br><i>Charles F. O'Donnell MD</i>  |  |  |  | 29c. LICENSE NUMBER<br><b>D-09383</b>   |  | 29d. DATE SIGNED (Month, Day, Year)<br><b>August 8, 1997</b>                                |  |   |  |
| 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)<br><b>Charles F. O'Donnell MD - 111 Hamlet Hill Rd Baltimore, Maryland 21200</b>   |  |  |  |   |  |   |  |   |  |
| 31. DATE FILED (Month, Day, Year)<br><b>AUG 08 1997</b>  |  | 32. REGISTRAR'S SIGNATURE<br><i>James W. Anderson</i>  |  |   |  |   |  |   |  |

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 23997

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Minnie McCARTIN

2. Date of Death

August 04 97 6pm

3. Time of Death

Funeral  
Director

4a. Facility Name (If not Institution, give street and number)

Gilchrist Center 6601 N. Charles St. Balto. MD 21204

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

220-20-6261

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

95

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth (Month, Day, Year)

May 9, 1902

9. Birthplace (State or Foreign Country)

Balto, MD

Usual Residence of Decedent

10a. State

Md

10b. County

Baltimore

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

8911 Harford Road

10f. Zip Code

21234

10g. Citizen of What Country?

U.S.A.

11. Marital Status

1 ☐ Never Married 2 ☐ Married3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S.

Armed Forces?

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

6th

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Homemaker

16b. Kind of Business/Industry

Own Home

17. Father's Name (First, Middle, Last)

Harry Davis

18. Mother's Name (First, Middle, Maiden Surname)

Lola Spencer

19a. Informant's Name/Relationship (Type, Print)

Rod Merson /Grandson

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7820 Wilson Avenue Balto, MD 21234

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Meadowridge Memorial 8/9

Date

20c. Location - City or Town, State

Dorsey, MD

21. Signature of Funeral Service Licensee

Michael Carpenter

22. Name and Address of Facility

Burgee-Henss Funeral Home  
3631 Falls Road Balto, MD 21211

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a.

End-stage dementia

Approximate Interval Between Onset and Death

6 months

Due to (or as a consequence of):

b.

multiple cerebral infarctions

years

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

None

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

W. Anthony Riley, MD

29c. License number

025205

29d. Date signed (Month, Day, Year)

August 4, 1997

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W. Anthony Riley 6701 N. Charles St. Balto. MD. 21204

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

John Davidson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

T




Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23998

## Certificate of Death

Reg. No.

|   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|---|---|--|---|--|--|--|---|---|--|---|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|--|-----------|--|--|--|--|--|--|--|--|--|----------------|----|--|--|--|--|--|--|--|--|--|
| Physician<br>/Medical<br>Examiner   | 1. Decedent's Name (First, Middle, Last)<br><b>DONALD THOMAS OHLE</b>   |  |   |  |  |  | 2. Date of Death<br>Month Day Year<br><b>AUGUST 4 1997</b>                    |   | 3. Time of Death<br><b>12:44 P</b>   |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 4a. Facility Name (If not institution, give street and number)<br><b>JOHNS HOPKINS BAYVIEW MEDICAL CENTER</b>   |  |   |  |  |  | 4b. City, Town, or Location of Death<br><b>BALTIMORE CITY</b>                 |   | 4c. County of Death<br><b>NONE</b>   |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| Funeral<br>Director   | 5. Social Security Number<br><b>578-34-1901</b>   |  | 6. Sex<br><input checked="" type="checkbox"/> M <input type="checkbox"/> F  |  | 7. Age (In yrs. last birthday)<br><b>67</b> Yrs.   |  | 8. Date of Birth (Month, Day, Year)<br><b>SEPTEMBER 3, 1929</b>               |   | 9. Birthplace (State or Foreign Country)<br><b>WASHINGTON D.C.</b>                             |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | Usual Residence of Decedent   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| To Be Completed by Funeral Director   | 10a. State<br><b>MD</b>   |  | 10b. County<br><b>BALTIMORE</b>   |  | 10c. City, Town or Location<br><b>DUNDALK</b>  |  |   |   | 10d. Inside City Limits<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 10e. Street and Number<br><b>3607 SOLLERS POINT RD.</b>   |  |   |  | 10f. Zip Code<br><b>21222</b>  |  | 10g. Citizen of What Country?<br><b>U.S.A.</b>                                |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 11. Marital Status<br><input type="checkbox"/> Never Married <input type="checkbox"/> Married<br><input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced  |  | 12. Was Decedent Ever in U.S. Armed Forces?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If Yes, Give Year or Dates: |  | 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No Specify: |  |   | 14. Race - American Indian, Black, White, etc.<br>Specify: <b>WHITE</b> |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 15. Decedent's Education (Specify only highest grade completed)<br>Elementary/Secondary (0-12) <b>12</b>  |  | College (1-4or 5+)  |  | 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)<br><b>FOREMAN</b>  |  |   | 16b. Kind of Business/Industry<br><b>M.T.A.</b>                         |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 17. Father's Name (First, Middle, Last)<br><b>EDWARD HENRY OHLE</b>   |  |   |  |  |  | 18. Mother's Name (First, Middle, Maiden Surname)<br><b>ALICE ELMA MINDER</b> |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| To Be Completed by Physician/Medical Examiner   | 19a. Informant's Name/Relationship (Type, Print)<br><b>DIANE RHOADES/ DAUGHTER</b>  |  |   |  | 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)<br><b>3607 SOLLERS POINT RD DUNDALK, MD 21222</b>  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 20a. Method of Disposition<br><input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State<br><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) |  | 20b. Place of Disposition (Name of cemetery, crematory or other place)<br><b>GARDEN DULANEY VALLEY MEM.</b>                                       |  | Date<br><b>8/8/97</b>  |  | 20c. Location - City or Town, State<br><b>TIMONIUM, MD</b>                    |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 21. Signature of Funeral Service Licensee<br>   |  |   |  | 22. Name and Address of Facility<br><b>BRADLEY-ASHTON FUNERAL HOME, INC. 2134 WILLOW SPRING RD. DUNDALK, MD 21222</b>  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.                             |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | Approximate Interval Between Onset and Death  |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| <table border="1"> <tr> <td rowspan="4">Immediate Cause (Final disease or condition resulting in death)</td> <td colspan="9">e. <b>COLLAPSED (R) LUNG</b><br/>Due to (or as a consequence of):</td> <td>1 day</td> </tr> <tr> <td rowspan="3">Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last</td> <td colspan="9">b. <b>CONGESTIVE HEART FAILURE</b><br/>Due to (or as a consequence of):</td> <td>mult yrs.</td> </tr> <tr> <td colspan="9">c. <b>ENDSTAGE RENAL DISEASE</b><br/>Due to (or as a consequence of):</td> <td>6 mos - 12 mos</td> </tr> <tr> <td colspan="9">d.</td> <td></td> </tr> </table> |   |  |   |  |  |  |   |   |  | Immediate Cause (Final disease or condition resulting in death) | e. <b>COLLAPSED (R) LUNG</b><br>Due to (or as a consequence of): |  |  |  |  |  |  |  |  | 1 day | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last | b. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of): |  |  |  |  |  |  |  |  | mult yrs. | c. <b>ENDSTAGE RENAL DISEASE</b><br>Due to (or as a consequence of): |  |  |  |  |  |  |  |  | 6 mos - 12 mos | d. |  |  |  |  |  |  |  |  |  |
| Immediate Cause (Final disease or condition resulting in death)   | e. <b>COLLAPSED (R) LUNG</b><br>Due to (or as a consequence of):  |  |   |  |  |  |   |   |  |   | 1 day  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   | Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  | b. <b>CONGESTIVE HEART FAILURE</b><br>Due to (or as a consequence of): |   |  |  |  |   |   |  |   | mult yrs.  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   |   | c. <b>ENDSTAGE RENAL DISEASE</b><br>Due to (or as a consequence of):   |   |  |  |  |   |   |  |   | 6 mos - 12 mos   |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
|   |   | d.   |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| <b>INSULIN DEPENDANT DIABETES MELITUS</b><br><br><b>CORONARY ARTERY DISEASE</b>   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 23b. Did tobacco use contribute to the cause of death?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Probably <input type="checkbox"/> Unknown  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 24a. Was an autopsy performed?<br><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 24b. Were autopsy findings available prior to completion of cause of death?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 25. Was case referred to medical examiner?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 26. Place of Death (Check only one)<br>Hospital: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 27. Manner of Death<br><input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 28a. Date of Injury (Month, Day Year)   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 28b. Time of Injury<br><b>M</b>   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 28c. Injury at Work?<br><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 28d. Describe how injury occurred   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 28f. Location (Street and Number or Rural Route Number, City or Town, State)  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 29a. Certifier (Check only one)<br><input checked="" type="checkbox"/> Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.<br><input type="checkbox"/> Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 29b. Signature and title of certifier<br>  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 29c. License number<br><b>97009</b>   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 29d. Date signed (Month, Day, Year)<br><b>AUGUST 4th, 1997</b>  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 30. Name and address of person who completed cause of death (Item 23e) (Type, Print)<br><b>SARDIA ALIZAI, MD 651-D St. Paul Street, Baltimore MD 21202</b>  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 31. Date filed (Month, Day, Year)<br><b>AUG 08 1997</b>   |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |
| 32. Registrar's Signature<br>  |   |  |   |  |  |  |   |   |  |   |  |  |  |  |  |  |  |  |  |       |  |  |  |  |  |  |  |  |  |  |           |  |  |  |  |  |  |  |  |  |                |    |  |  |  |  |  |  |  |  |  |

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "Natural", or items 23a or 24a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit certificate.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

State  
Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

97 23999

## Certificate of Death

Reg. No.

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

GLORIA QUEEN

2. Date of Death

Month

Day

Year

3. Time of Death

0253

4a. Facility Name (If not institution, give street and number)

MERCY MEDICAL CENTER

4b. City, Town, or Location of Death

BALTIMORE

4c. County of Death

BALTIMORE

Funeral  
Director

5. Social Security Number

212-30-304

8. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

65 Yrs.

If Under 1 Year

Months

If Under 24 Hrs.

Hours

8. Date of Birth

(Month, Day, Year)

11-20-31

9. Birthplace (State or Foreign Country)

Maryland

Usual Residence of Decedent

10a. State

Maryland

10b. County

N/A

10c. City, Town or Location

Baltimore

10d. Inside City Limits

1 ☒ Yes 2 ☐ No

10e. Street and Number

2107 N. Pulaski St.

10f. Zip Code

21217

10g. Citizen of What Country?

USA

11. Marital Status

1 ☐ Never Married2 ☒ Married3 ☐ Widowed4 ☐ Divorced

12. Was Decedent Ever in U.S.

1 ☐ Yes 2 ☒ No

If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No)

1 ☐ Yes 2 ☒ No

Specify:

14. Race - American Indian, Black, White, etc.

Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

12

College (1-4 or 5+)

0

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Volunteer

16b. Kind of Business/Industry

State School

17. Father's Name (First, Middle, Last)

unknown

18. Mother's Name (First, Middle, Maiden Surname)

Martha Brown

19a. Informant's Name/Relationship (Type, Print)

Mr. Leonard Queen (son)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

3626 Oakmont Ave. Balto. Md. 21215

20a. Method of Disposition

1 ☒ Burial2 ☐ Cremation3 ☐ Removal from State4 ☐ Donation5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Arbutus

Date

8/9/97

20c. Location - City or Town, State

Balto. Co. Md.

21. Signature of Funeral Service Licensee

Joseph L. Russ

22. Name and Address of Facility

Joseph L. Russ Funeral Home  
2222 W. North Ave. Balto. Md. 21216

23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e.

ANOXIA

Due to (or as a consequence of):

Approximate Interval Between Onset and Death

30 min.

Sequently list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b.

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

RESPIRATORY FAILURE

END STAGE METASTATIC OVARIAN CANCER

DEEP VENOUS THROMBOSIS.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes2 ☒ No3 ☐ Probably4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes2 ☒ No

25. Was case referred to medical examiner?

1 ☐ Yes 2 ☒ No

Hospital:

1 ☒ Inpatient2 ☐ ER/Outpatient3 ☐ DOA

Other:

4 ☐ Nursing Home5 ☐ Residence6 ☐ Other (Specify)

27. Manner of Death

1 ☒ Natural2 ☐ Accident3 ☐ Suicide4 ☐ Homicide5 ☐ Pending Investigation6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

28b. Time of Injury

M

28c. Injury at Work?

1 ☐ Yes2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 ☒ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

M. Koth, M.D.

29c. License number

P09833

29d. Date signed (Month, Day, Year)

8-5-97

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hitesh Kothari, MD 301 St Paul St, Baltimore, MD 21202

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

J. Jackson-Randall

State  
Registrar

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

T



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

## Certificate of Death

Reg. No.

97 24000

Physician  
/Medical  
Examiner

1. Decedent's Name (First, Middle, Last)

Reva Ralph

2. Date of Death

August 5

Day

1997

Year

3. Time of Death

10:25pm

Funeral  
Director

4a. Facility Name (If not institution, give street and number)

Gilchrist Center 6601 N. Charles Street

4b. City, Town, or Location of Death

Baltimore

4c. County of Death

Baltimore

5. Social Security Number

347-10-4824

6. Sex

1 ☐ M 2 ☒ F

7. Age (In yrs. last birthday)

80

Yrs.

If Under 1 Year

Months Days

If Under 24 Hrs.

Hours Min.

8. Date of Birth

March 19, 1917

9. Birthplace (State or Foreign Country)

Illinois

Usual Residence of Decedent

10e. State

Pennsylvania

10b. County

Northampton

10c. City, Town or Location

Easton

10d. Inside City Limits

1 ☐ Yes 2 ☒ No

10e. Street and Number

2040 Lehigh Street

10f. Zip Code

18042

10g. Citizen of What Country?

United States

11. Marital Status

1 ☐ Never Married 2 ☐ Married  
3 ☒ Widowed 4 ☐ Divorced

12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No  
If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☒ No Specify:

14. Race - American Indian, Black, White, etc.

Specify: White

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12)

College (1-4 or 5+)

2

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Manager

16b. Kind of Business/Industry

Retail Furniture

17. Father's Name (First, Middle, Last)

Samuel Sandler

18. Mother's Name (First, Middle, Maiden Surname)

Rose Weisser

19a. Informant's Name/Relationship (Type, Print)

Mr. Roger Ralph / Son

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

4 Glenberry Court Phoenix, Maryland 21131

20a. Method of Disposition

1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State  
4 ☐ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

Easton Cemetery

Date

8/8/97

20c. Location - City or Town, State

Easton, Pennsylvania

21. Signature of Funeral Service Licensee

Brian A. Willem

22. Name and Address of Facility

Leonard J. Ruck Funeral Home, Inc.

5305 Harford Road Baltimore, Maryland 21214

23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

e. acute leukemia

Approximate Interval Between Onset and Death

6 weeks

Sequitally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):  
c. Due to (or as a consequence of):  
d. Due to (or as a consequence of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed?

1 ☐ Yes 2 ☒ No

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No25. Was case referred to medical examiner?  
1 ☐ Yes 2 ☒ No

Hospital:

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

26. Place of Death (Check only one)

Other:

4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify)

Hospice

27. Manner of Death

1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide  
5 ☐ Pending investigation 6 ☐ Could not be determined

28a. Date of Injury (Month, Day, Year)

None

28b. Time of Injury

M

28c. Injury et Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

29a. Certifier (Check only one)

29b. Signature and title of certifier  
29c. License number  
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

W. A. Riley G. B. Inc 6701 N. Charles St Balto. Md 2120x

31. Date filed (Month, Day, Year)

AUG 08 1997

32. Registrar's Signature

Julia David-Randall

Baltimore, Maryland 21215-0020

Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician  
/Medical  
Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit form.

Medical Certification: To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

T

State  
Registrar

